Washington State Health Care Authority

Medicaid

Medicaid Provider Billing Workshop

Presenters:

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Matt Ashton, Provider Relations Unit

Bill Camerer, Provider Relations Unit

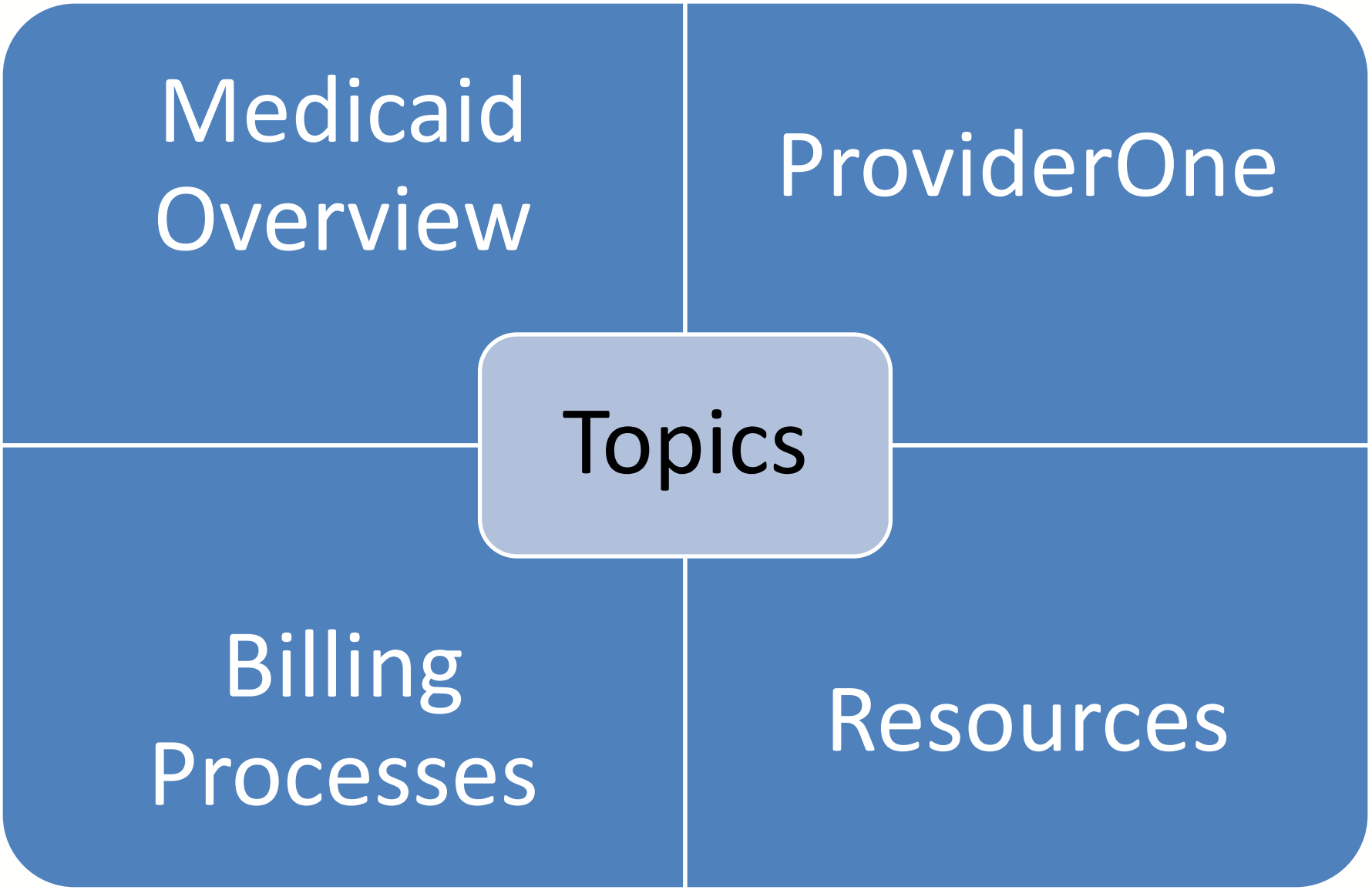
March 2015

Who is Provider Relations and what do we do?

Provide outreach and training for Washington Apple Health (Medicaid) providers

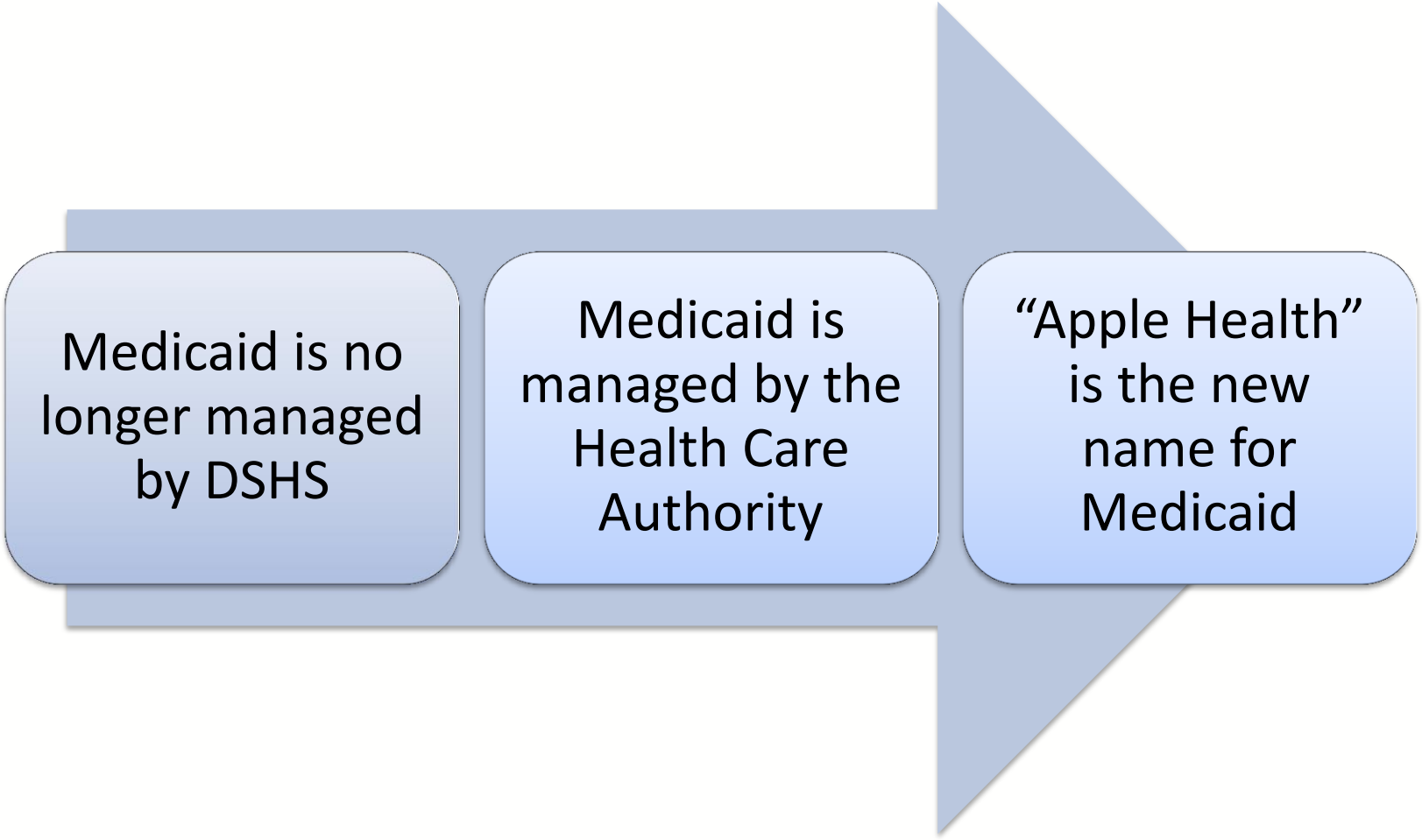
Specialize in the use of the ProviderOne portal

Assist with program and policy questions


Medicaid Overview
ProviderOne
Topics
Billing Processes
Resources

Medicaid Overview

Medicaid Overview



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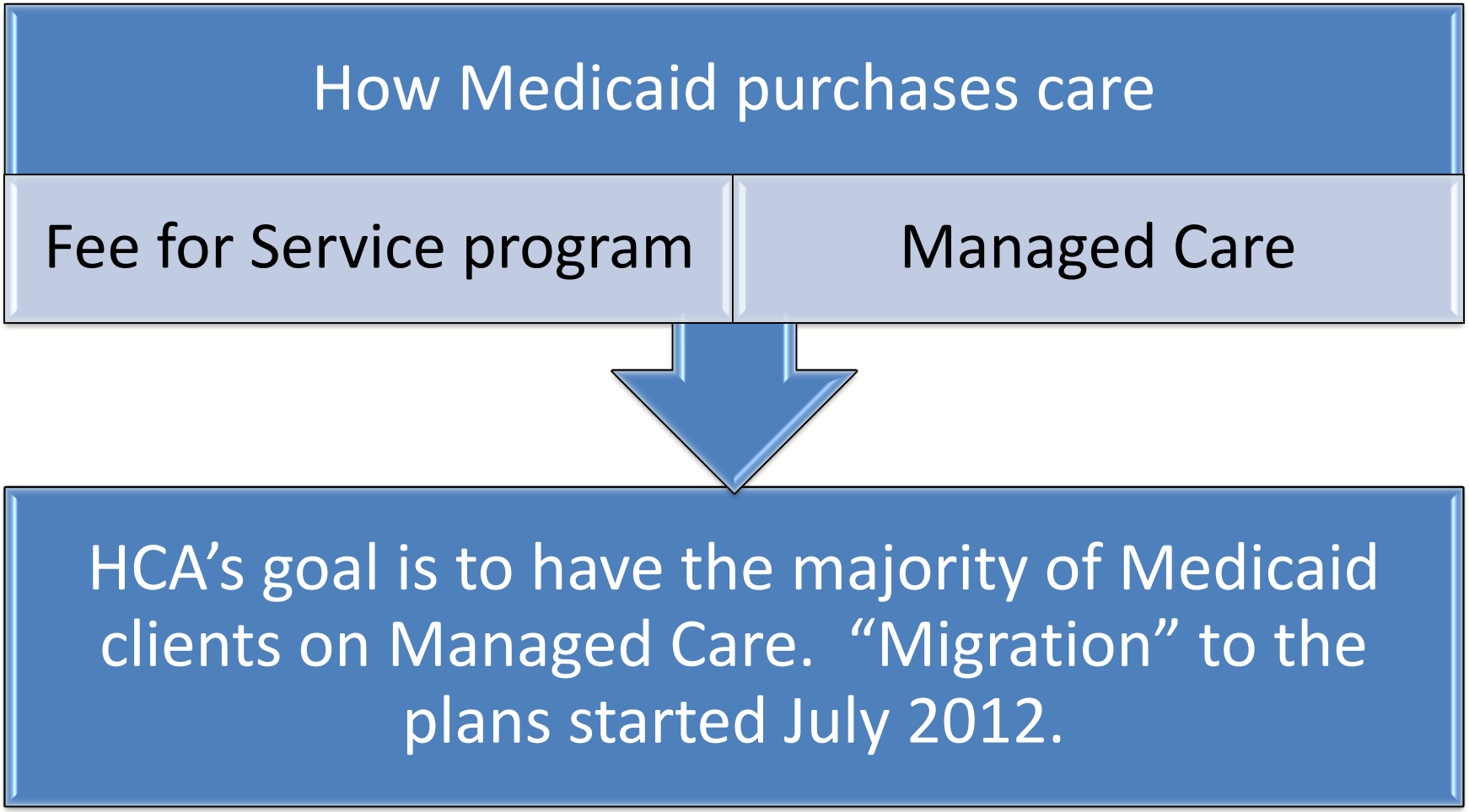
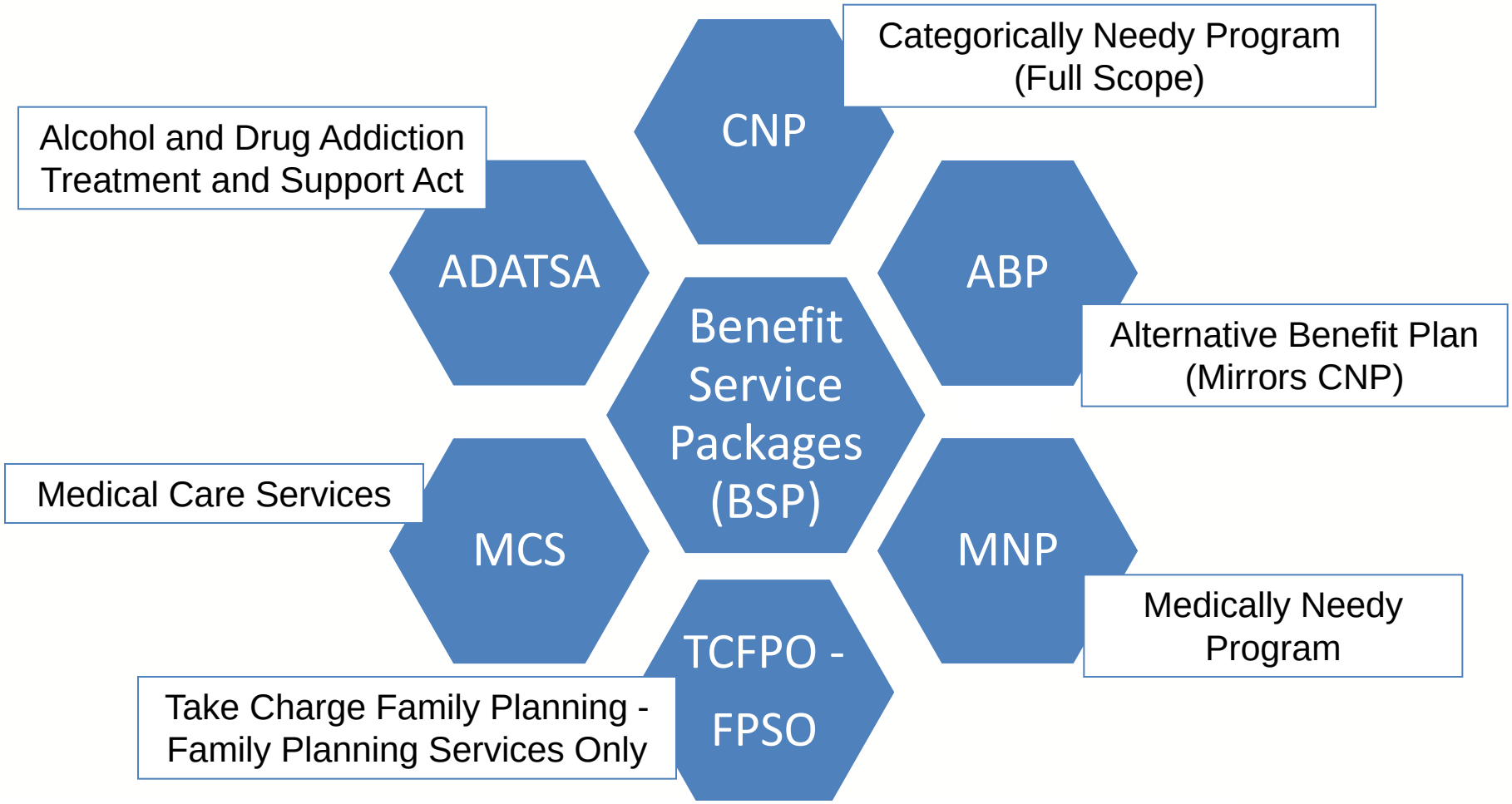
Medicaid Overview



Eligibility Programs



For complete listing of BSP, visit:
http://www.hca.wa.gov/medicaid/provider/Documents/provideroneguide/appendix_e.pdf

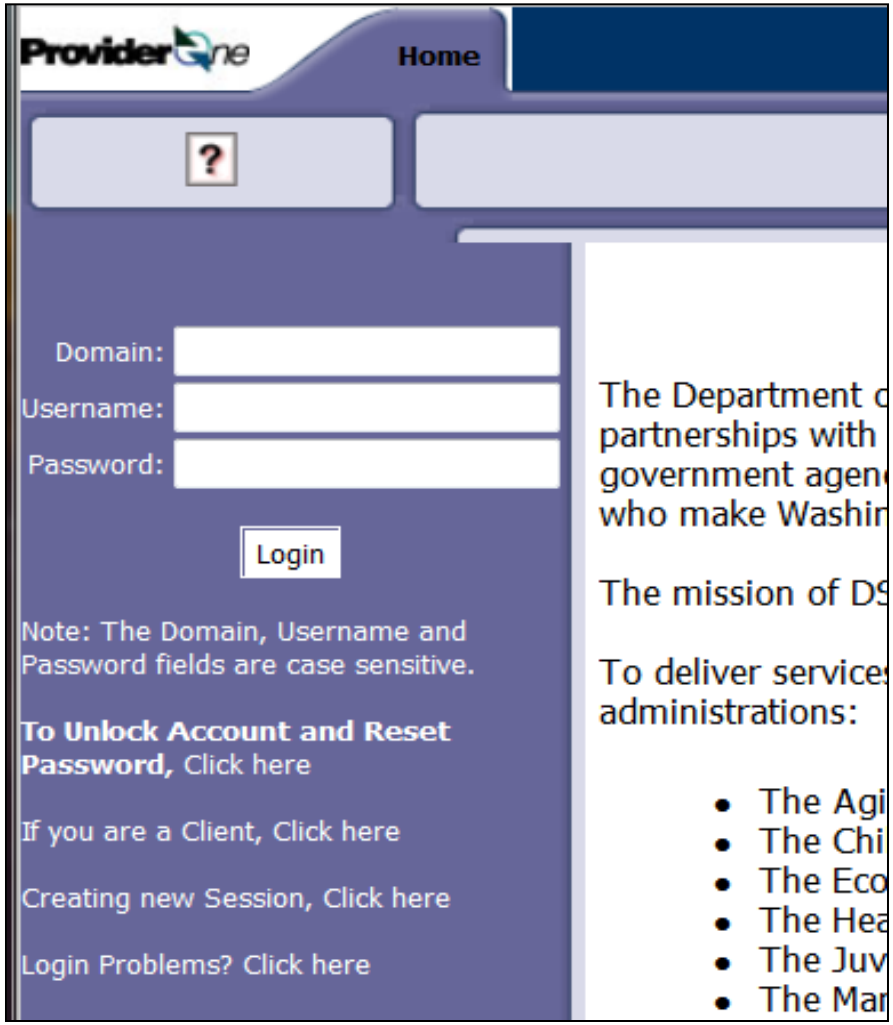
ProviderOne

Accessing ProviderOne

- Before logging into ProviderOne:
  - ✓ Make sure you are using Microsoft Internet Explorer version 6.0 and above
  - ✓ Turn **OFF** the Pop Up Blocker
  - ✓ Make sure you are using a PC (MACs are not supported by ProviderOne)

Accessing ProviderOne

- ✓ Use web address https://www.waproviderone.org
- ✓ Ensure that your system **"Pop Up Blocker"** is turned **"OFF"**
- ✓ Login using assigned Domain, Username, and Password
- ✓ Click on the **"Login"** button



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ProviderOne Users

HCA establishes System Administrators for your domain/NPI

- A System Administrator can assign profiles to other users as necessary
- Staff can be assigned one or more security profiles to meet their job duties and provide them the level of access necessary in the system.

ProviderOne Security web page link:
http://www.hca.wa.gov/medicaid/providerone/pages/phase1/security.aspx

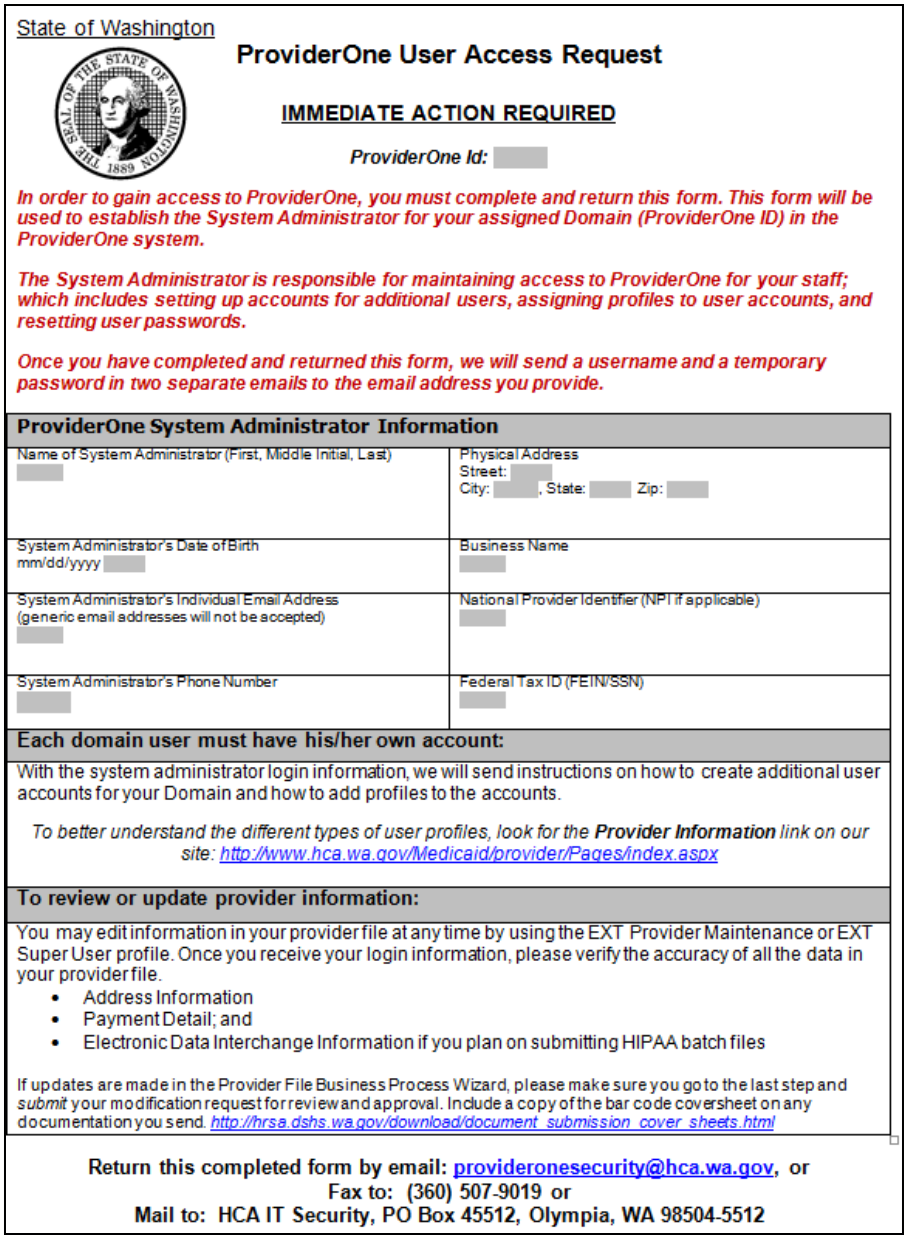
How to Get Access in ProviderOne

- Review the ProviderOne Security Manual at http://www.hca.wa.gov/medicaid/providerone/pages/phase1/security.aspx

- New provider and don't have the form? Email ProviderOne Security at: providerone security@hca.wa.gov (in the subject line enter "Request for ProviderOne User Access Request form")

How to Get Access in ProviderOne

- The ProviderOne User Access Request form is for a newly enrolled Facility, Clinic, Individual Provider, or a new Office Administrator.
- Complete the form and fax to: 360-507-9019.



State of Washington

ProviderOne User Access Request

IMMEDIATE ACTION REQUIRED

ProviderOne Id:

In order to gain access to ProviderOne, you must complete and return this form. This form will be used to establish the System Administrator for your assigned Domain (ProviderOne ID) in the ProviderOne system.

The System Administrator is responsible for maintaining access to ProviderOne for your staff; which includes setting up accounts for additional users, assigning profiles to user accounts, and resetting user passwords.

Once you have completed and returned this form, we will send a username and a temporary password in two separate emails to the email address you provide.

ProviderOne System Administrator Information	
Name of System Administrator (First, Middle Initial, Last)	Physical Address Street: City: , State: Zip:
System Administrator's Date of Birth mm/dd/yyyy	Business Name
System Administrator's Individual Email Address (generic email addresses will not be accepted)	National Provider Identifier (NPI if applicable)
System Administrator's Phone Number	Federal Tax ID (FEIN/SSN)

Each domain user must have his/her own account:

With the system administrator login information, we will send instructions on how to create additional user accounts for your Domain and how to add profiles to the accounts.

*To better understand the different types of user profiles, look for the **Provider Information** link on our site: http://www.hca.wa.gov/Medicaid/provider/Pages/index.aspx*

To review or update provider information:

You may edit information in your provider file at any time by using the EXT Provider Maintenance or EXT Super User profile. Once you receive your login information, please verify the accuracy of all the data in your provider file.

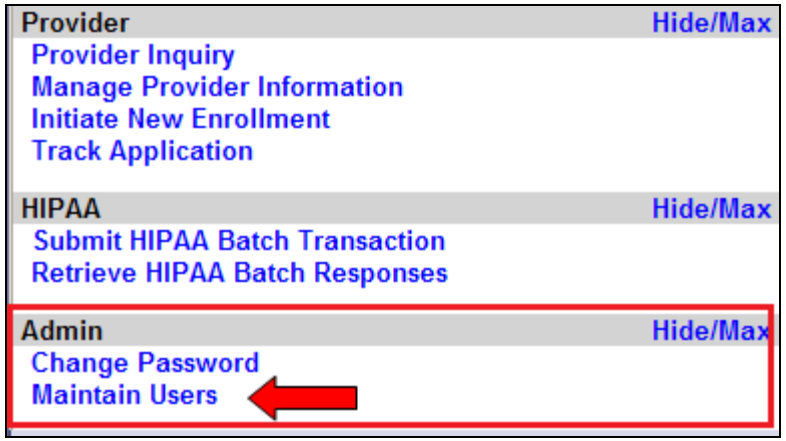
- Address Information
- Payment Detail; and
- Electronic Data Interchange Information if you plan on submitting HIPAA batch files

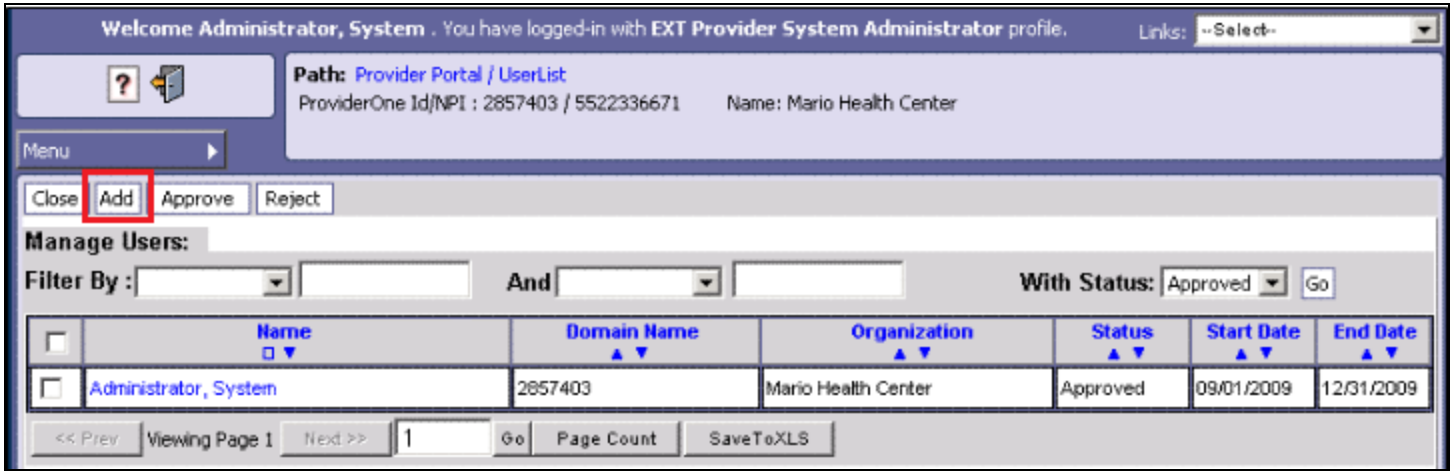
If updates are made in the Provider File Business Process Wizard, please make sure you go to the last step and *submit* your modification request for review and approval. Include a copy of the bar code coversheet on any documentation you send. http://hrsa.dshs.wa.gov/download/document_submission_cover_sheets.html

Return this completed form by email: provideronesecurity@hca.wa.gov, or
Fax to: (360) 507-9019 or
Mail to: HCA IT Security, PO Box 45512, Olympia, WA 98504-5512

How to Set Up a User

- Log in with the **System Administrator** Profile
- Click on **Maintain Users**
- The system now displays the User List screen
- Click on the **Add** button





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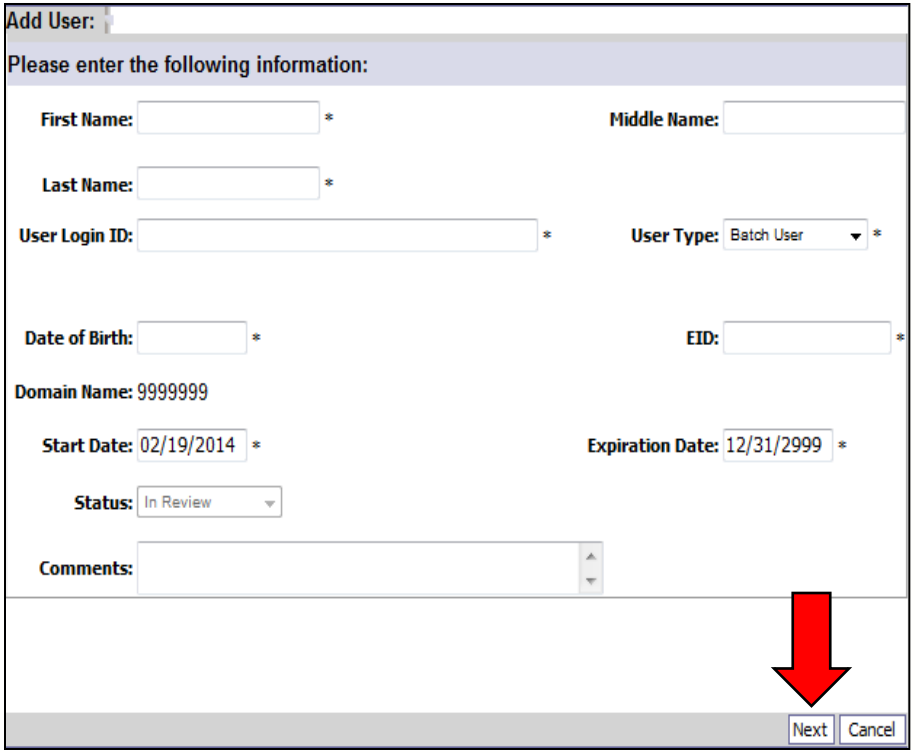
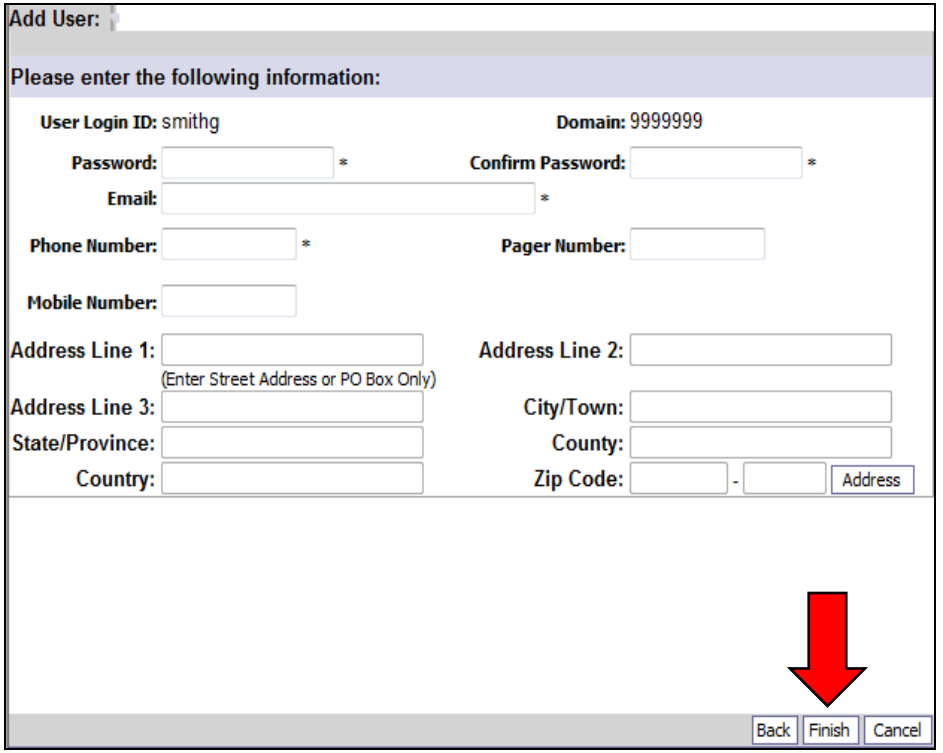
How to Set Up a User

- Adding a user





- Fill in all required boxes that have an asterisk *
- The address is not needed here

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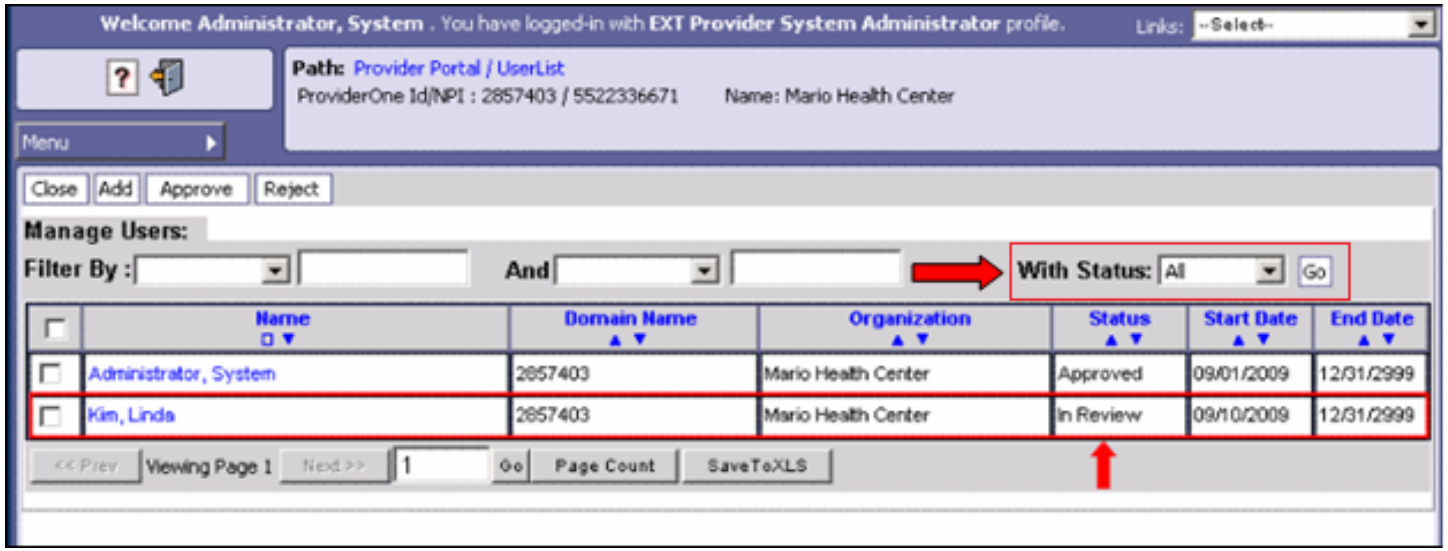
How to Set Up a User

- To Display the new user
  - ✓ In the **With Status** box display **In Review**, then click **Go**
  - ✓ The user's name is displayed with In Review status.
  - ✓ Click the box left of the user's name, then click the **Approve** button to approve this user.



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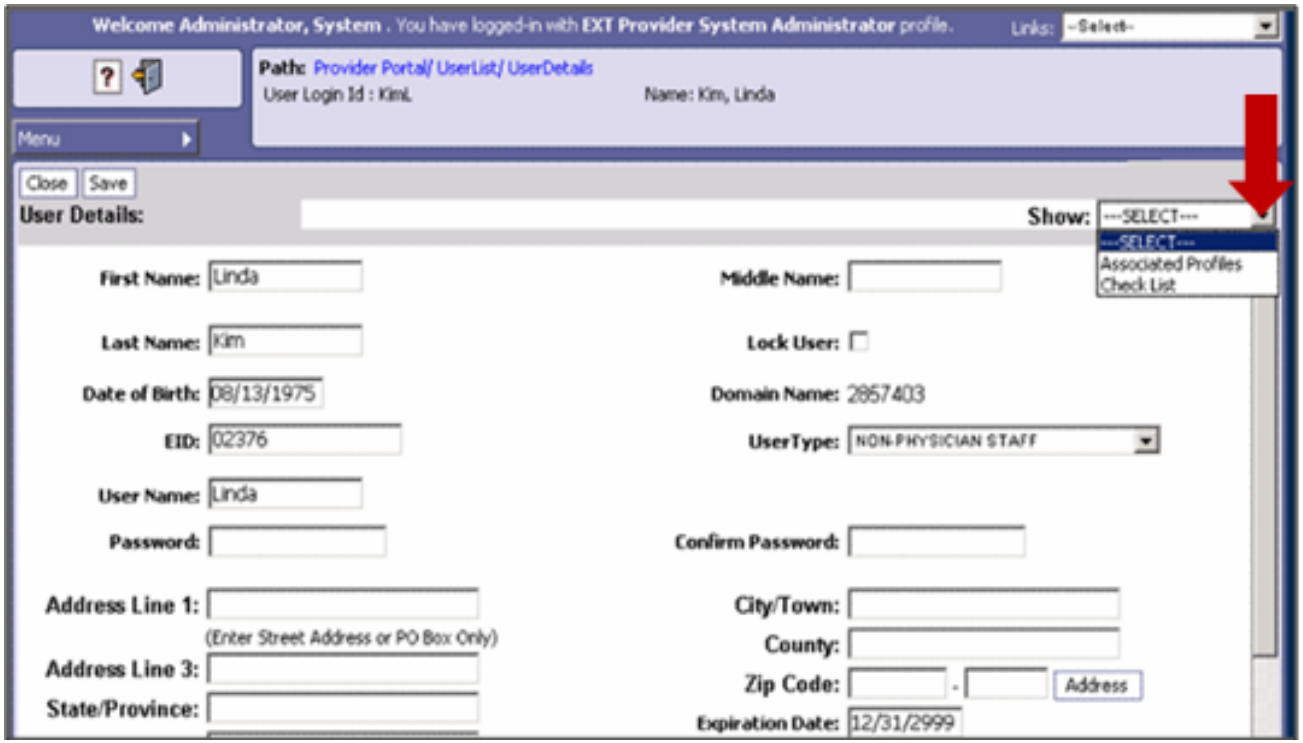
How to Set Up a User

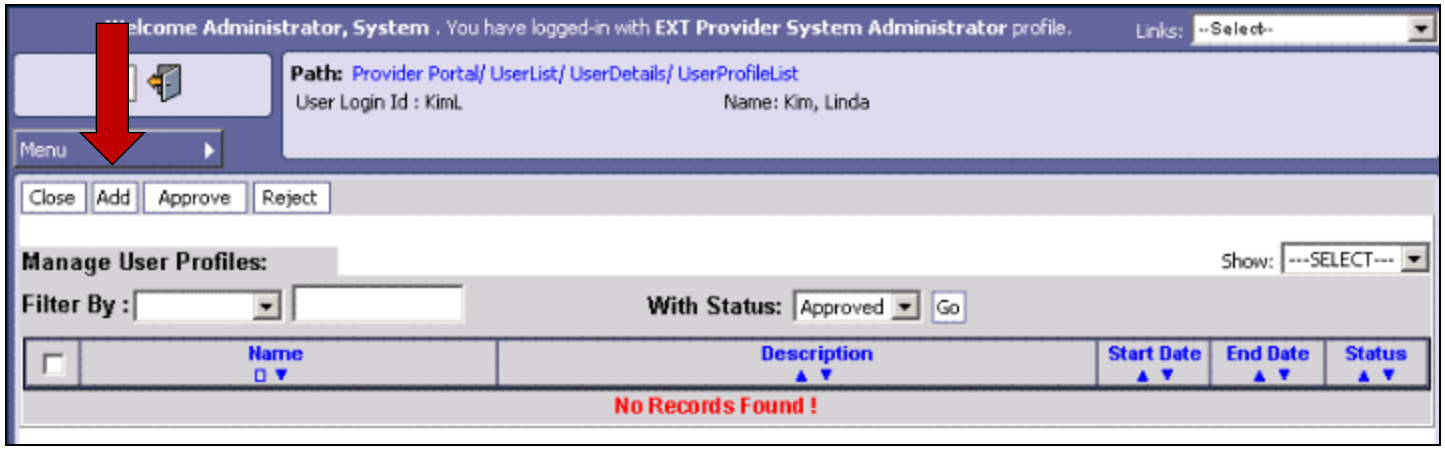
- Adding Profiles
  - ✓ Get here by clicking on the users name on the previous screen.



  - ✓ On the Show menu click on **Associated Profiles**.

How to Set Up a User

- Adding Profiles
  - ✓ Click on the **Add** button to select profiles



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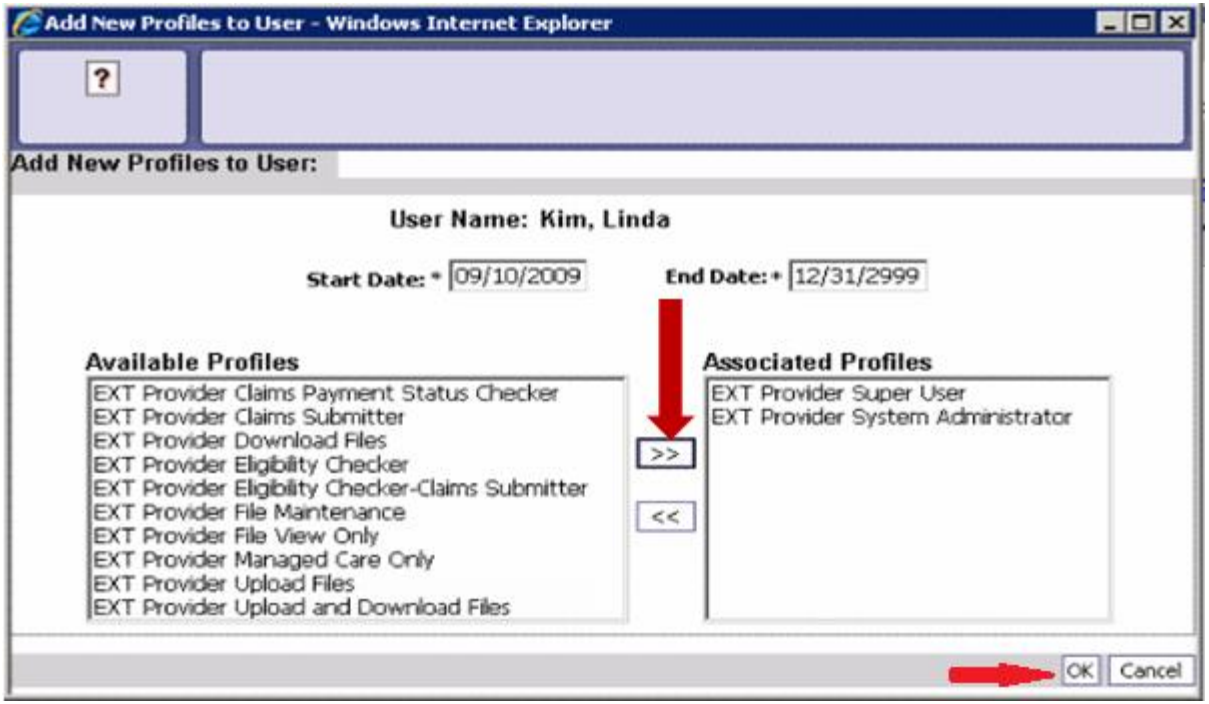
How to Set Up a User

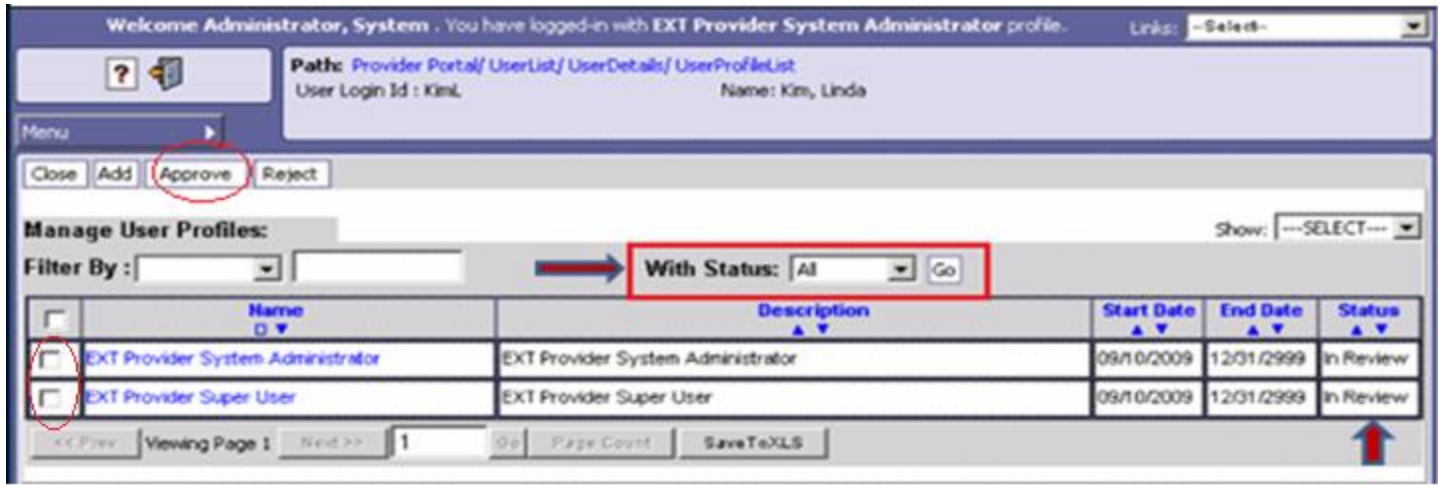
- Adding Profiles



- Highlight Available Profiles desired
  - ✓ Click **double arrow** and move to Associated Profiles box then click the **OK** button.

How to Set Up a User

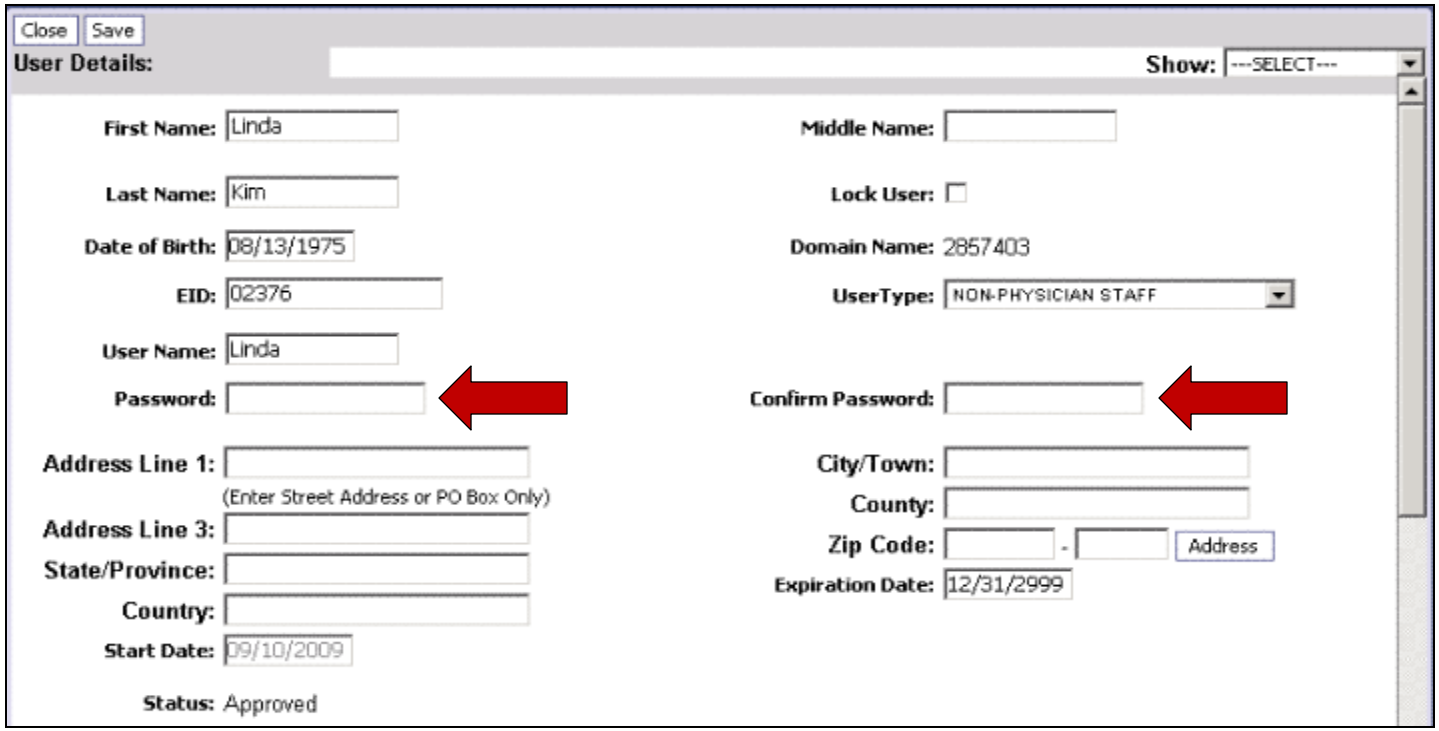
- Adding Profiles



- To Display the new profiles
  - ✓ In the **With Status** box display **All**, then click **Go**.
  - ✓ The profiles are displayed with In Review status.
  - ✓ Click the box left of the profile name, then click the **Approv**e button. Profiles will then be approved.

How to Set Up a User

- How to set up a user's password



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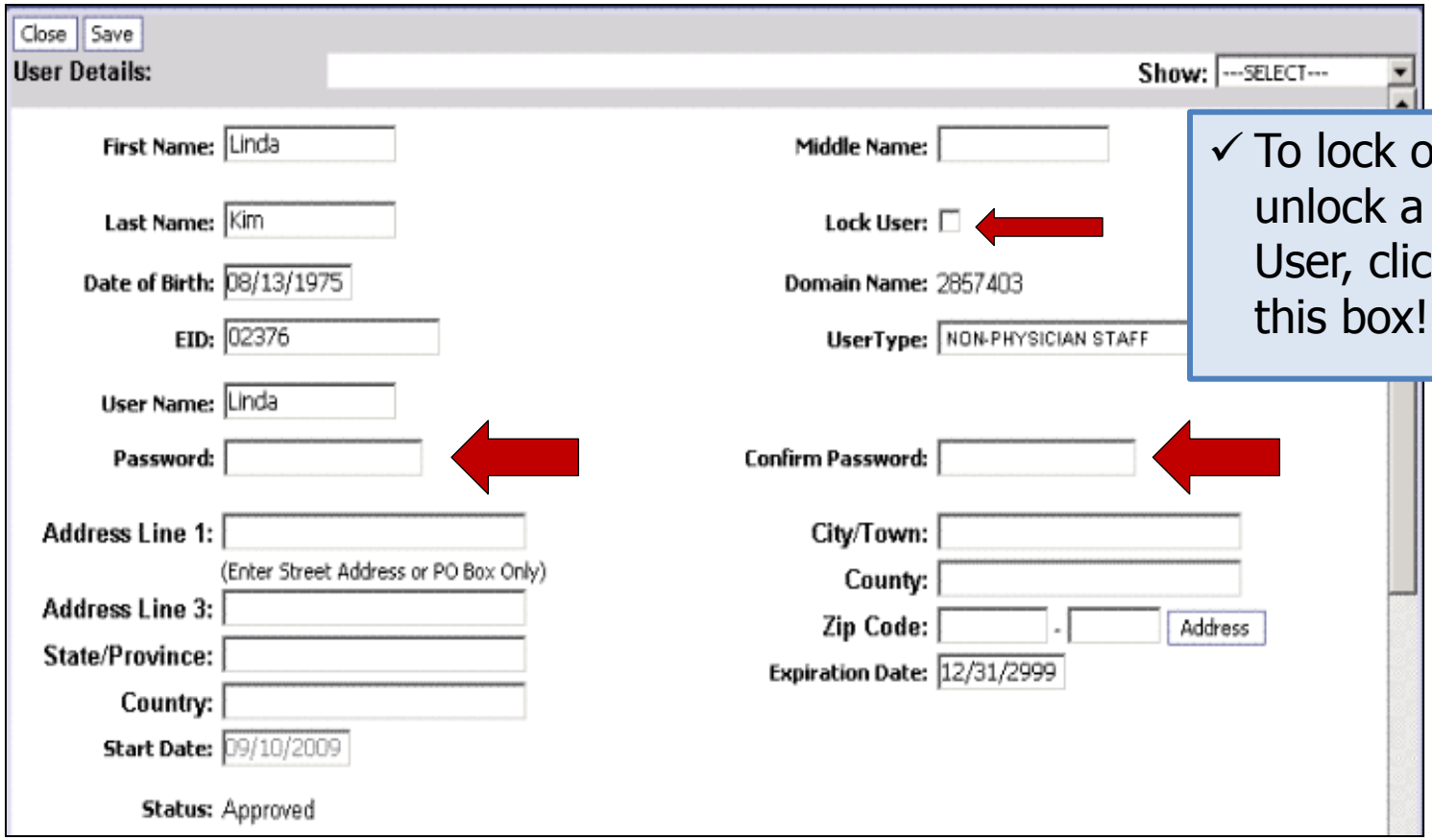
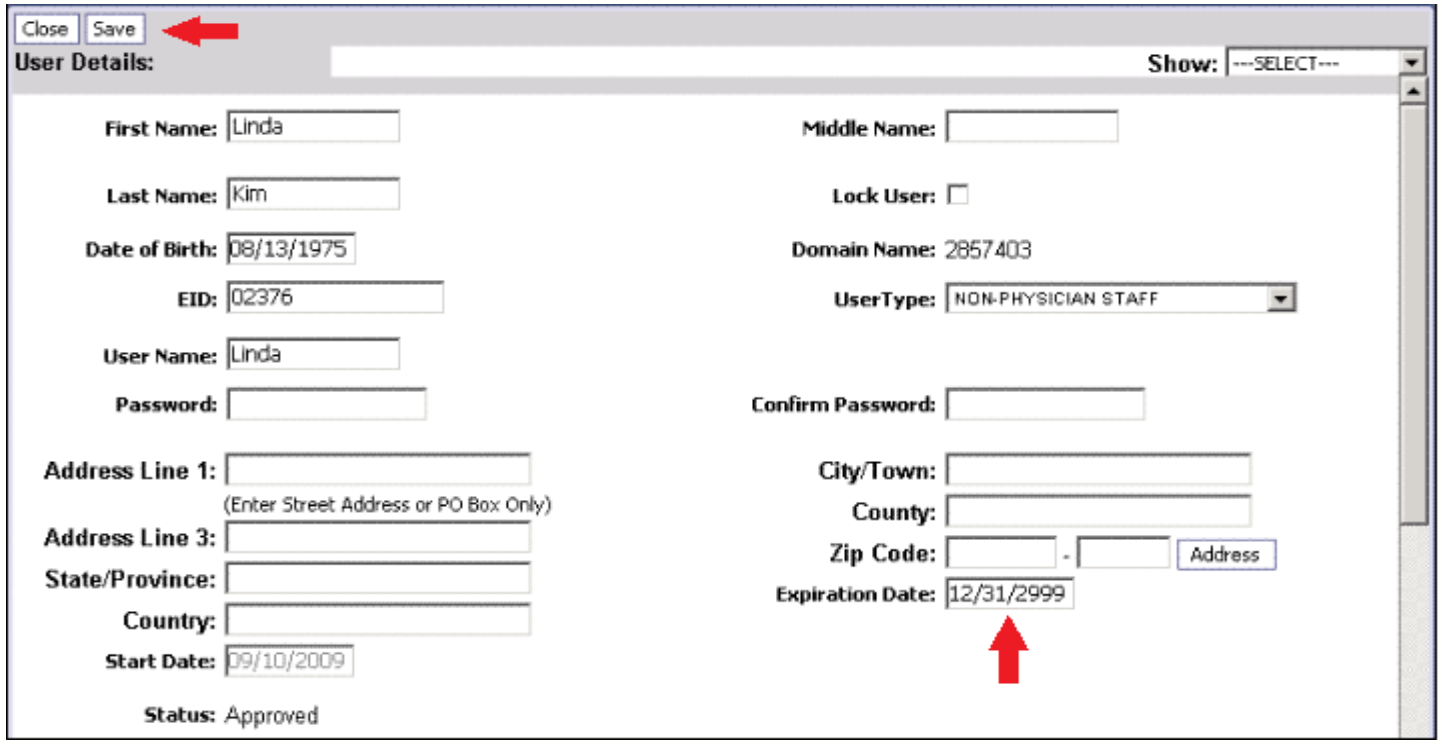
How to Manage a User

- How to reset a password
  - Enter the new temporary password and click **Save**



How to Manage a User

- How to end a user in ProviderOne



- ✓ Enter the end date and click the **save** button.
- ✓ The account will be removed from view after the system refreshes overnight.

How can we help?

Provider Enrollment

- Assists with enrollment of billing/servicing providers
- Can be contacted at 800-562-3022, ext. 16137

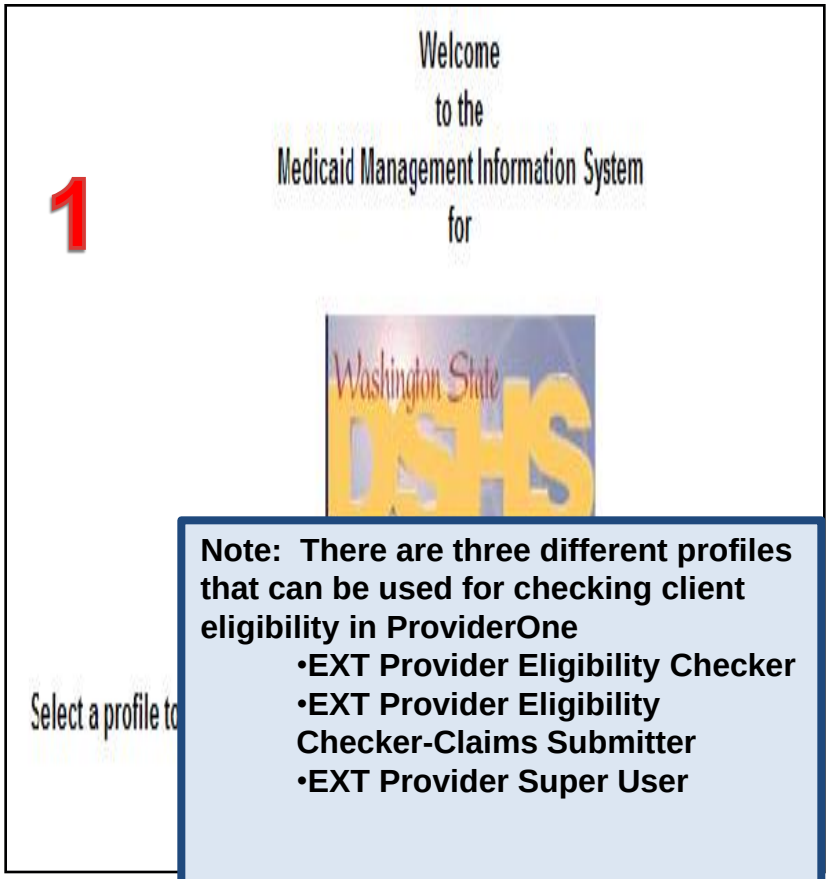
User profiles

- Provider Relations can assist in a variety of formats tailored to individual needs
- To request assistance, send email to providerrelations@hca.wa.gov

Eligibility

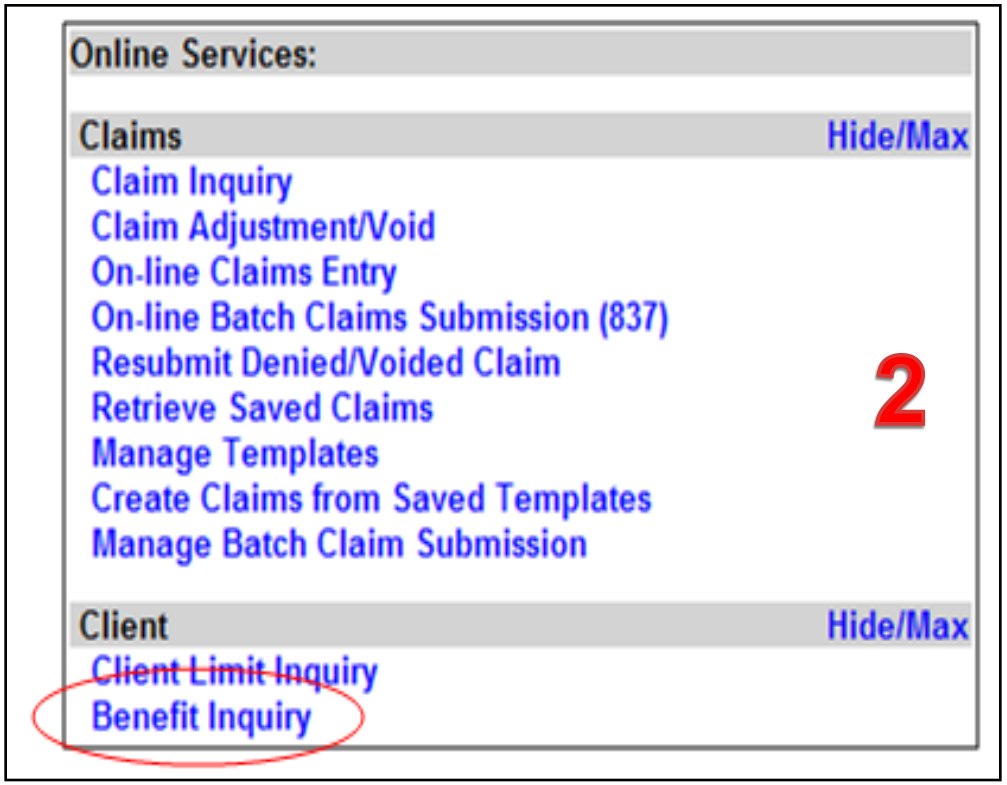
How Do I Obtain Eligibility In ProviderOne

- Select the proper user profile



Note: There are three different profiles that can be used for checking client eligibility in ProviderOne

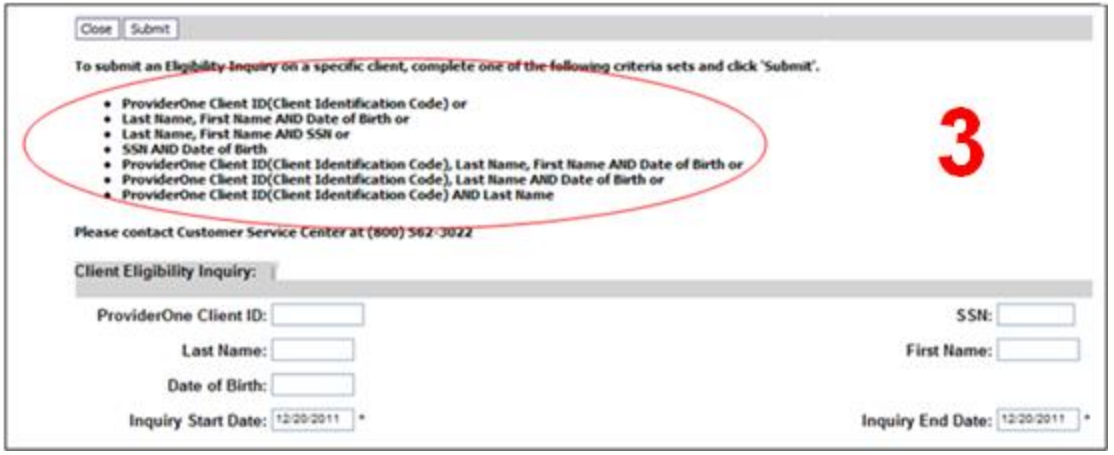
- **EXT Provider Eligibility Checker**
- **EXT Provider Eligibility Checker-Claims Submitter**
- **EXT Provider Super User**



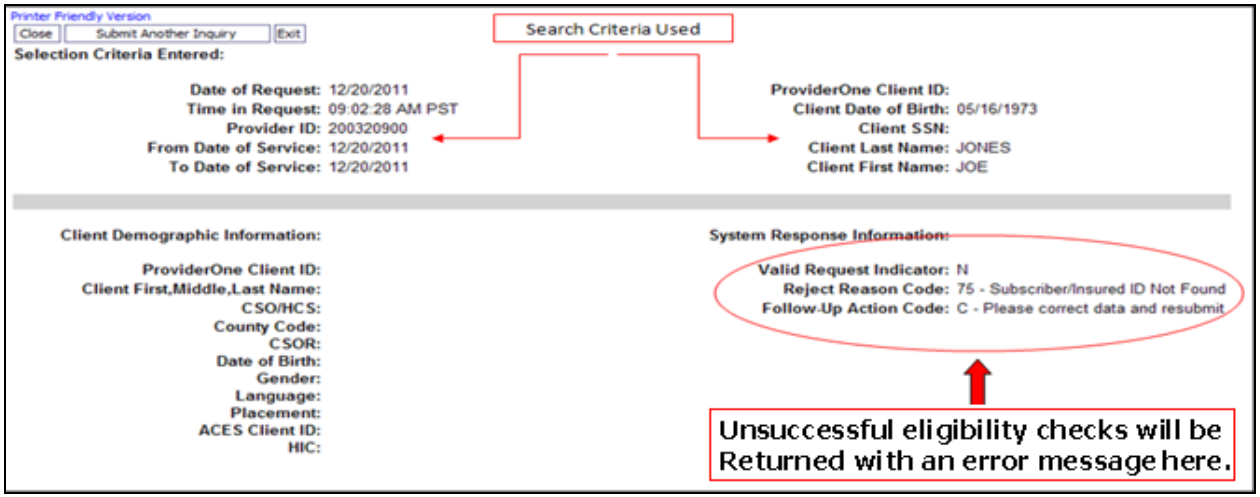
Select "Benefit Inquiry" under the "Client" section of the Provider Portal

How Do I Obtain Eligibility In ProviderOne

- Use one of the search criteria listed along with the dates of service to verify eligibility.



- An unsuccessful check would look like this:



✓ Client is not eligible for your search dates; or

✓ Check your keying!

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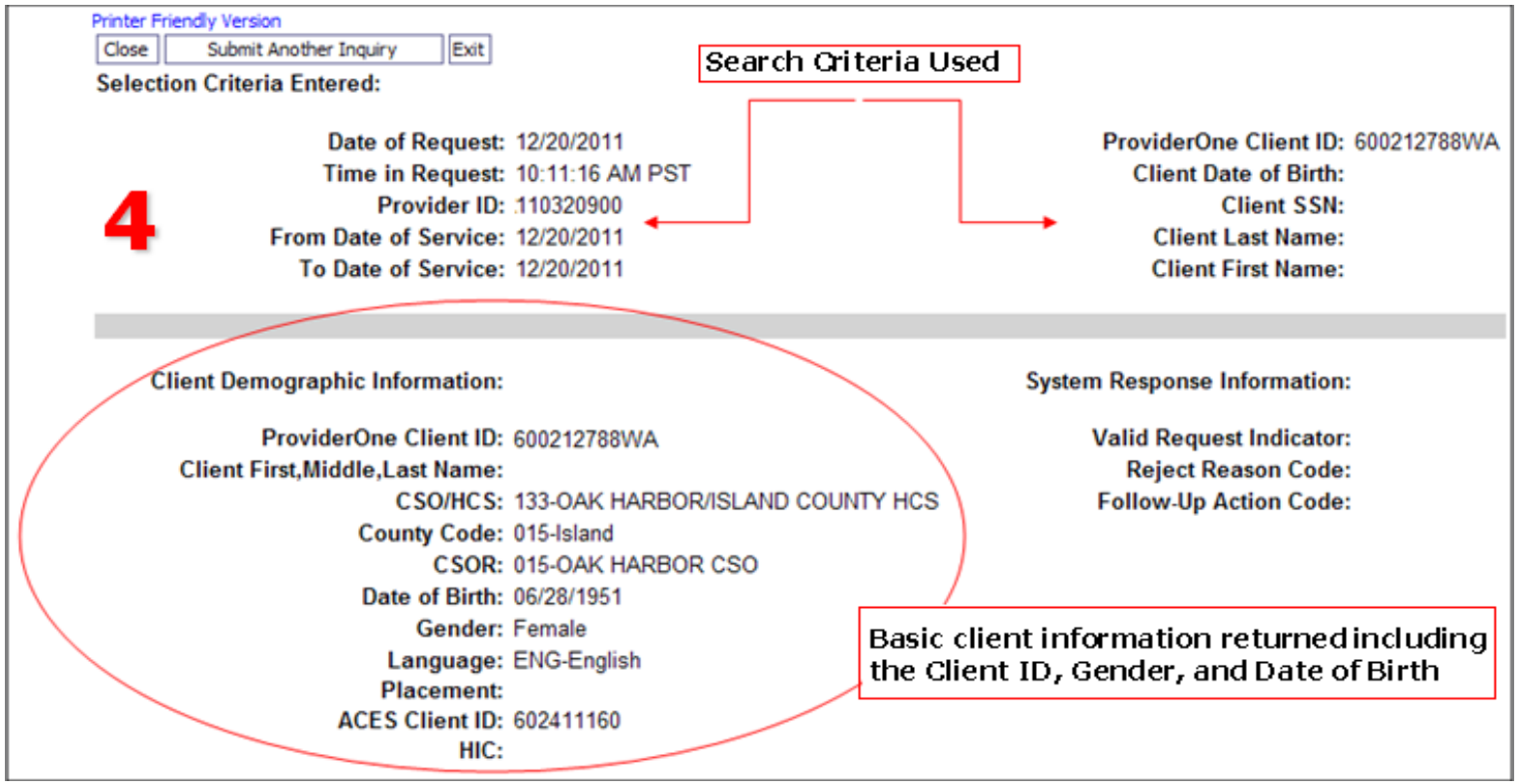
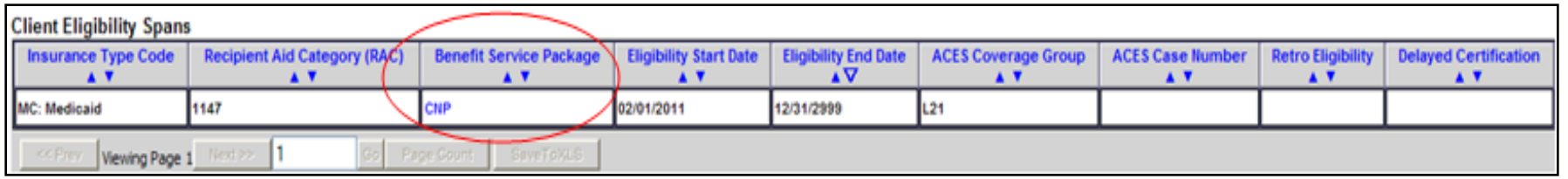
Successful Eligibility Check



Note: The eligibility information can be printed out using the "**Printer Friendly Version**" link located in the upper left corner.

Successful Eligibility Checks

- After scrolling down the page the first entry is the "**Client Eligibility Spans**" which shows:
  - ✓ The eligibility program (CNP, MNP, etc).
  - ✓ The date span for coverage.



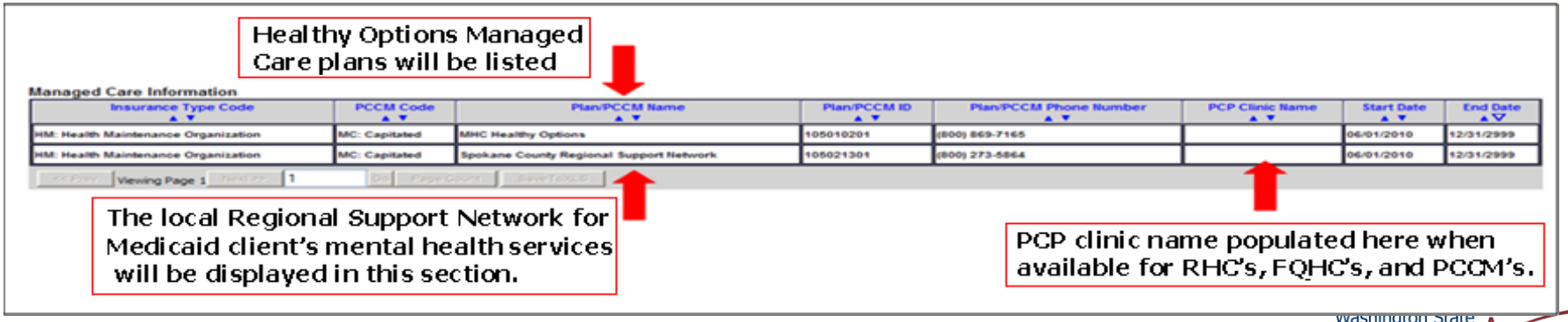
Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1147	CNP	02/01/2011	12/31/2999	L21			

<< Prev | Viewing Page 1 | Next >> | 1 | Go | Page Count | Save To XLS

Note: Clicking on the "**CNP**" hyperlink will display the "Benefit Service Package" which is a list of covered services for the client.

"Managed Care Information"



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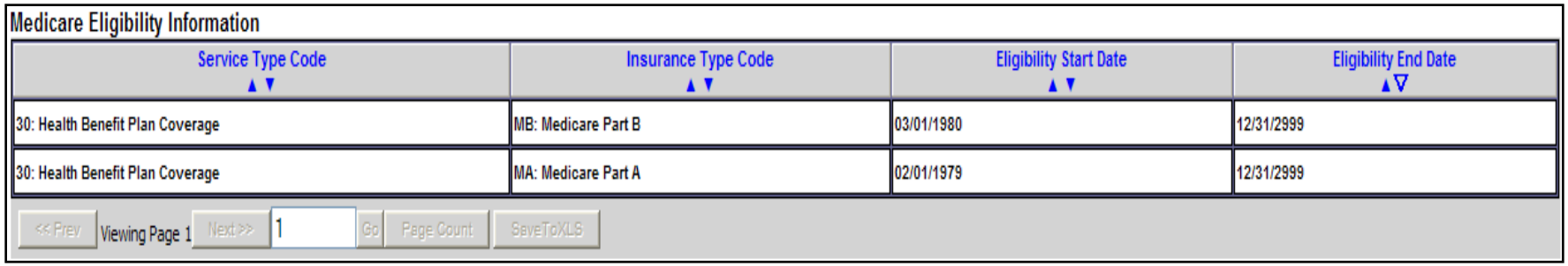
Successful Eligibility Checks

"Medicare Eligibility Information"



Medicare Eligibility Information

Service Type Code	Insurance Type Code	Eligibility Start Date	Eligibility End Date
30: Health Benefit Plan Coverage	MB: Medicare Part B	03/01/1980	12/31/2999
30: Health Benefit Plan Coverage	MA: Medicare Part A	02/01/1979	12/31/2999

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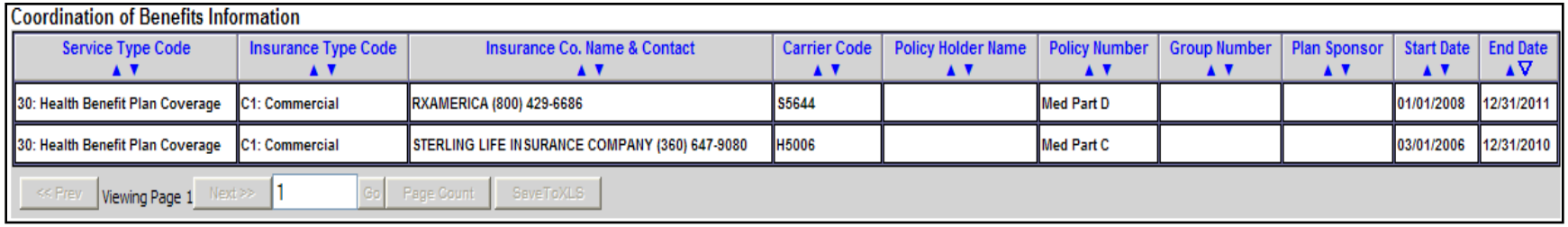
- If client has Medicare Part A or Part B this information will be shown with the Medicare eligibility effective dates of service.
- If the client has enrolled in a Medicare Advantage Plan (Part C), if reported, it is listed in the **"Coordination of Benefits Information"** section.



Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	RXAMERICA (800) 429-6686	S5644		Med Part D			01/01/2008	12/31/2011
30: Health Benefit Plan Coverage	C1: Commercial	STERLING LIFE INSURANCE COMPANY (360) 647-9080	H5006		Med Part C			03/01/2006	12/31/2010

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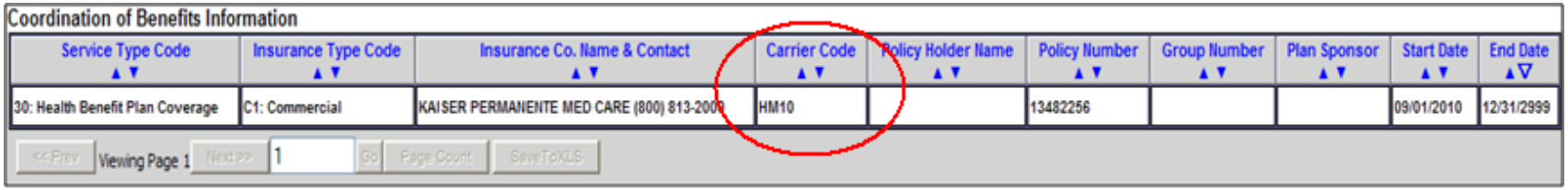
Successful Eligibility Checks

"Coordination of Benefits Information"

- Will display phone number and any policy or group numbers on file with WA Medicaid for the commercial plans listed.
- For DDE claims the Carrier Code (Ins. ID) is found here.



Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	KAISER PERMANENTE MED CARE (800) 813-2000	HM10		13482256			09/01/2010	12/31/2999

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- There are two ways to update any COB information in ProviderOne:
  - Provider or client can contact COB 1-800-562-3022 extension 16134
  - Submit claim with EOB information which can be used to update ProviderOne.

Successful Eligibility Checks

"Restricted Client Information"

- Client's may be restricted to specific Hospitals, PCP's, and Pharmacies for care. A referral is required from the PCP for specialized care.

Restricted Client Information

Assignment Type	Provider Name	Provider Phone Number	Period Start Date	Period End Date
Hospital	MULTICARE HEALTH SYSTEM		01/05/2010	12/31/2999
Pharmacy	WALGREEN CO		01/01/2010	12/31/2999
Primary Care Physician	SEA-MAR COMMUNITY HEALTH CENTER		01/01/2010	12/31/2999
Primary Care Physician	DITTMER, STEPHANIE		01/01/2010	12/31/2999

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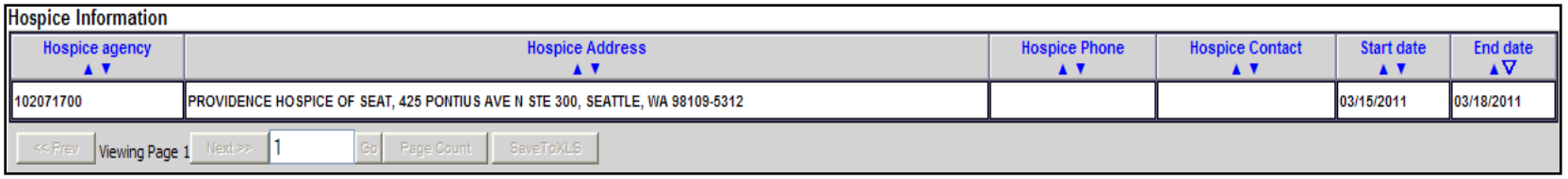
Successful Eligibility Checks

"Hospice Information"

- Client's may be enrolled in a Hospice agency for care:



Hospice Information

Hospice agency	Hospice Address	Hospice Phone	Hospice Contact	Start date	End date
102071700	PROVIDENCE HOSPICE OF SEAT, 425 PONTIUS AVE N STE 300, SEATTLE, WA 98109-5312			03/15/2011	03/18/2011

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Note: If a client is assigned to a Hospice agency, bill the Hospice agency for any care related to the client's terminal illness. WA Medicaid has paid a monthly payment to the agency to cover these services.

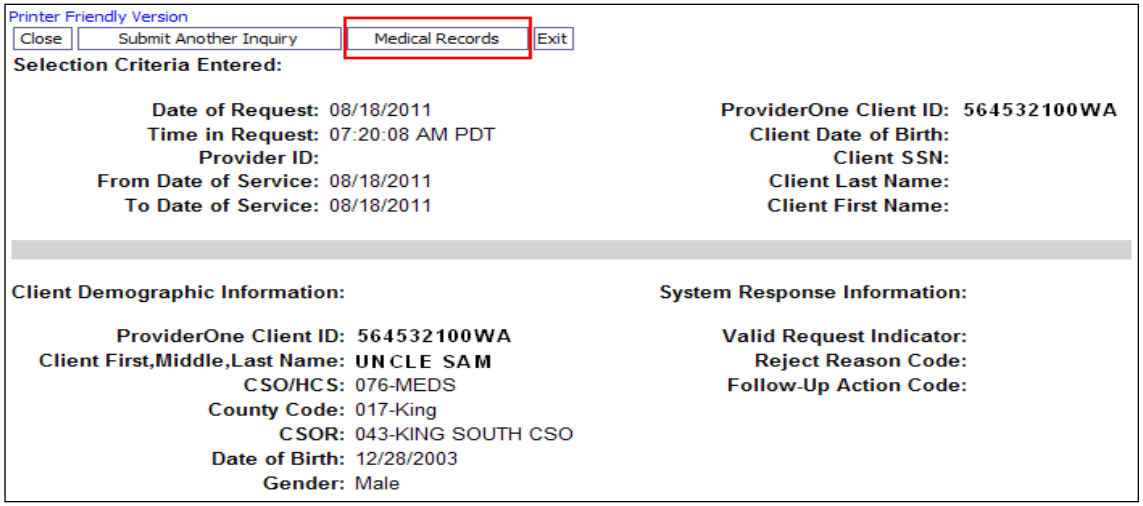
Note: If service is not related to the client's terminal illness, bill these services to WA Medicaid with a note "SCI=K" or with a statement "Not related to terminal illness".

- The last section of the eligibility check lists the source of the eligibility data.

Successful Eligibility Checks

"Foster Care Information"

- Foster Care Client's Medical Records History is available.
  - ✓ There is an extra button at the top of the eligibility screen.


Printer Friendly Version

Close | Submit Another Inquiry | Medical Records | Exit

Selection Criteria Entered:

Date of Request:	08/18/2011	**ProviderOne Client ID:**	564532100WA
Time in Request:	07:20:08 AM PDT	**Client Date of Birth:**	
Provider ID:		**Client SSN:**	
From Date of Service:	08/18/2011	**Client Last Name:**	
To Date of Service:	08/18/2011	**Client First Name:**	

Client Demographic Information:

ProviderOne Client ID:	564532100WA
Client First,Middle,Last Name:	UNCLE SAM
CSO/HCS:	076-MEDS
County Code:	017-King
CSOR:	043-KING SOUTH CSO
Date of Birth:	12/28/2003
Gender:	Male

System Response Information:

Valid Request Indicator:	
Reject Reason Code:	
Follow-Up Action Code:	

  - ✓ Click the button to see:
    - Pharmacy services claims.
    - Medical services claims (includes dental).
    - Hospital services claims.
- See the Billing and Resource Guide for complete details. Web address is on the last slide.

Successful Eligibility Checks

"Foster Care Information"

➢ Foster Care Client's Medical Records History shows claims paid by ProviderOne. Each section looks like:

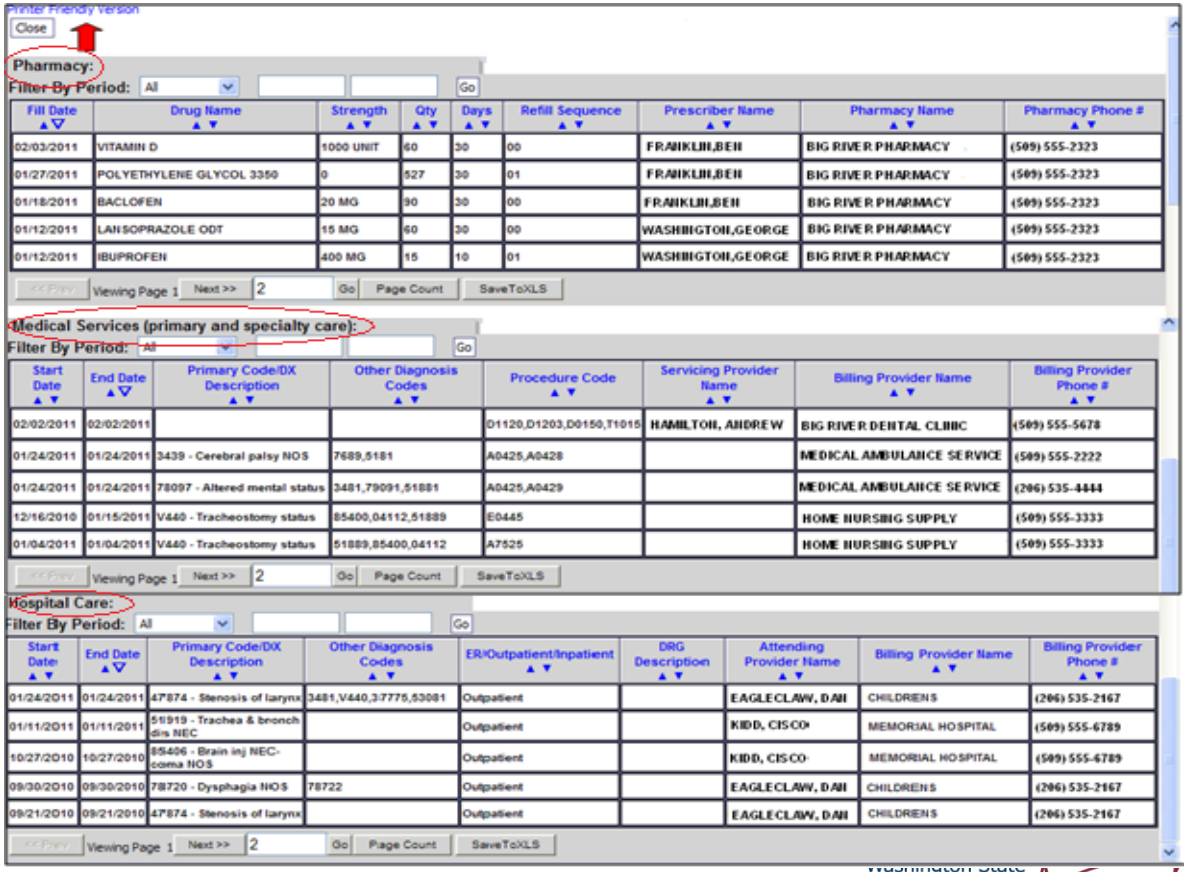
- ✓ If any field is empty there is no data for it.
- ✓ Sort by using the "diamonds" under each column name: 

- ✓ Search by using the "Filter by Period" boxes.
- ✓ If there is more pages of data use the "Next" or "Previous" buttons:

<< Prev Viewing Page 1 Next >>

- ✓ If there is no data for the section it will display:

No Records Found !



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Direct Data Entry Claims (DDE)

After this training, you can:

- Submit FFS direct data entry (DDE) claims
- Create and Submit TPL secondary DDE claims
  - ✓ With backup
  - ✓ Without backup
- Submit TPL secondary claims electronically
  - ✓ Without BU
- Bill Medicare crossovers (XO) and commercial private insurance (TPL) on same claim
- No information about pharmacy claims is discussed in this training

Direct Data Entry Claims (DDE)

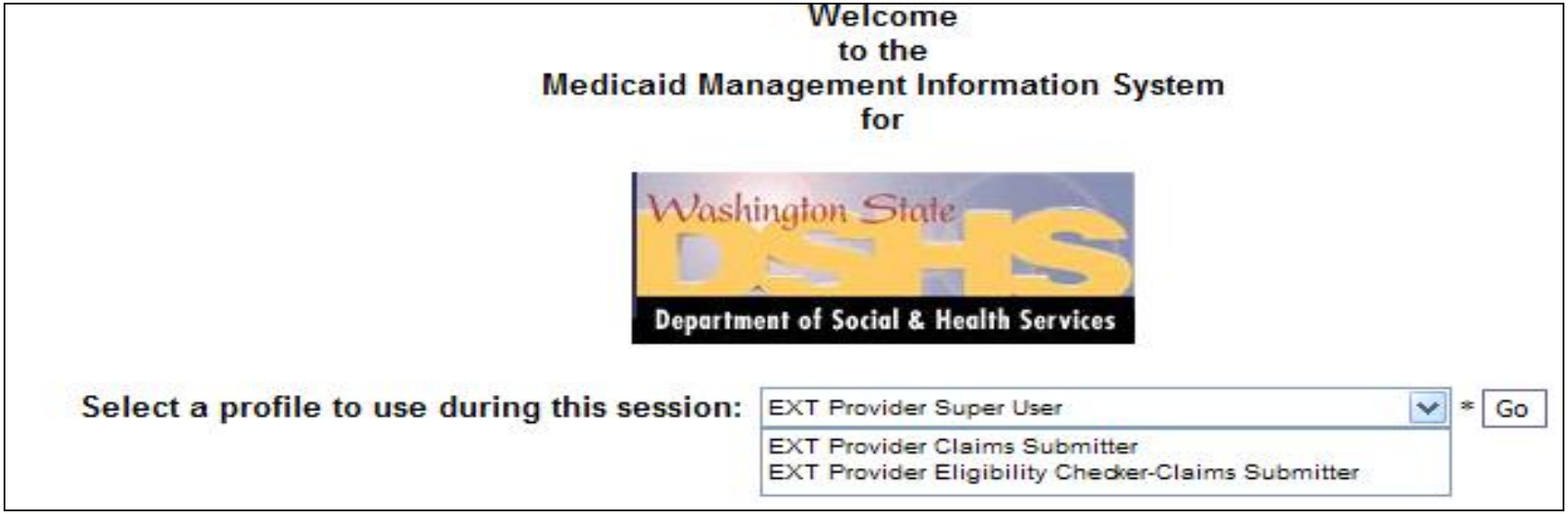
- ProviderOne allows providers to enter claims directly into the payment system
- All claim types can be submitted through the DDE system
  - ✓ Professional (CMS 1500)
  - ✓ Institutional (UB-04)
  - ✓ Dental (ADA Form)
- Providers can correct and resubmit denied or previously voided claims
- Providers can ADJUST or VOID previously paid claims

Accessing ProviderOne

- Use web address https://www.waproviderone.org
- Ensure that your system **"Pop Up Blocker"** is turned **"OFF"**
- Login using assigned Domain, Username, and Password
- Click on the **"Login"** button

Washington State Health Care Authority

Determine what profile to use



For claims submission choose one of the following profiles:

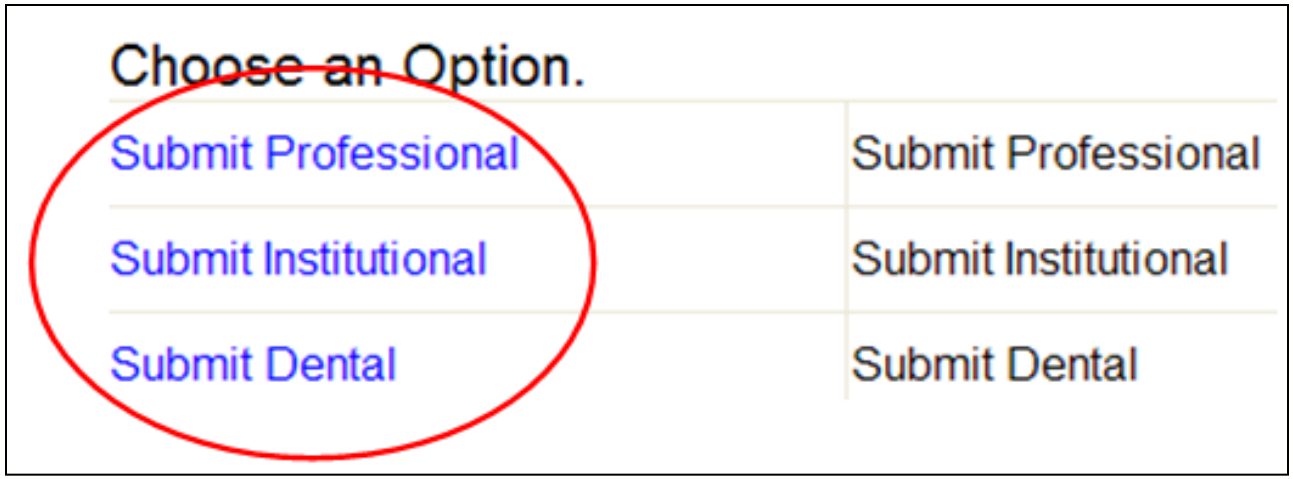
- EXT Provider Super User
- EXT Provider Claims Submitter
- EXT Provider Eligibility Checker – Claims Submitter

Direct Data Entry Claims (DDE)

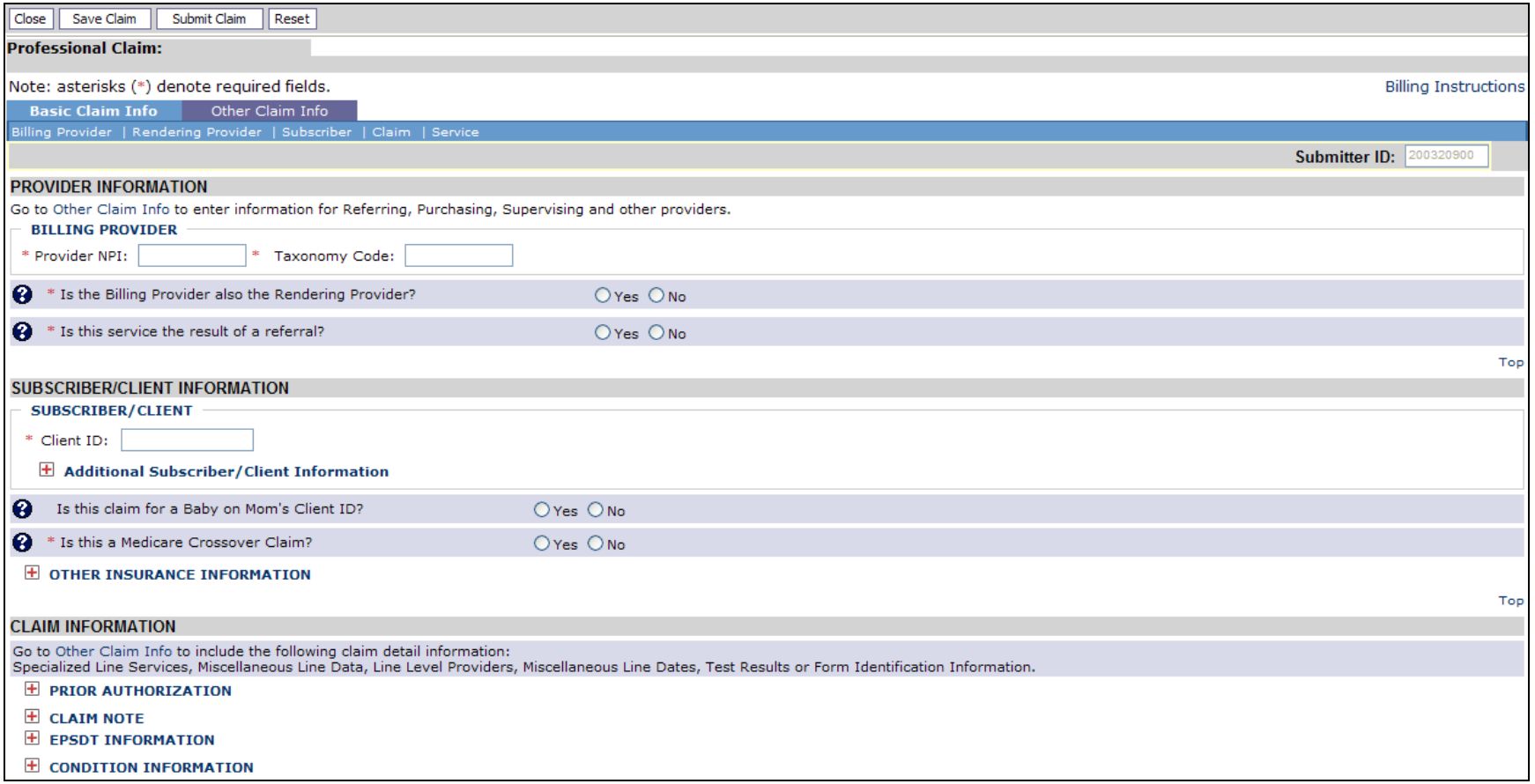
- From the Provider Portal select the "Online Claims Entry" option located under the "Claims" heading.

Direct Data Entry Claims (DDE)

- Choose the type of claim that you would like to submit.
  - ✓ Professional is the CMS 1500
  - ✓ Institutional is the UB04
  - ✓ Dental is the 2006 ADA form

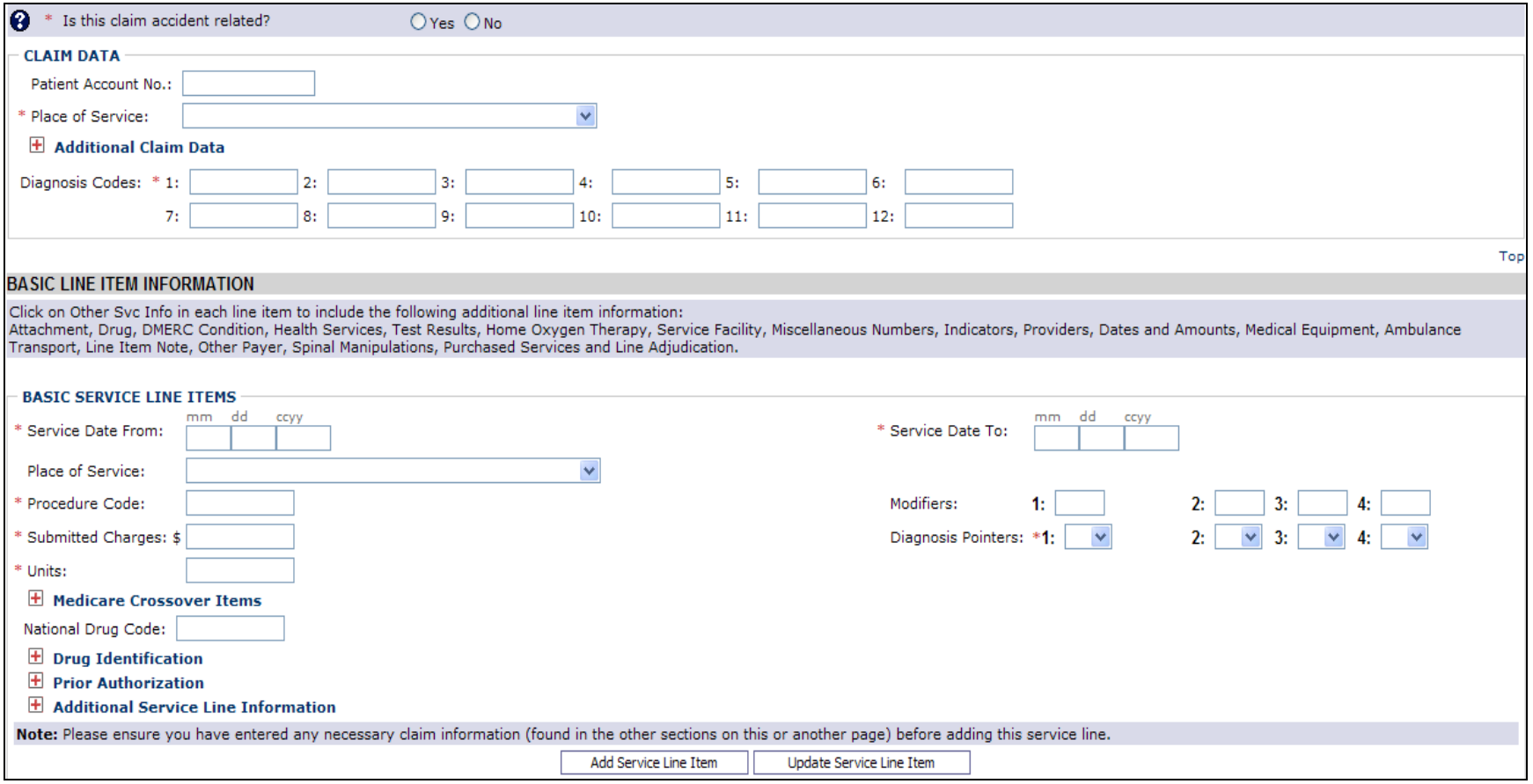


Direct Data Entry Claims (DDE)



Washington State Health Care Authority

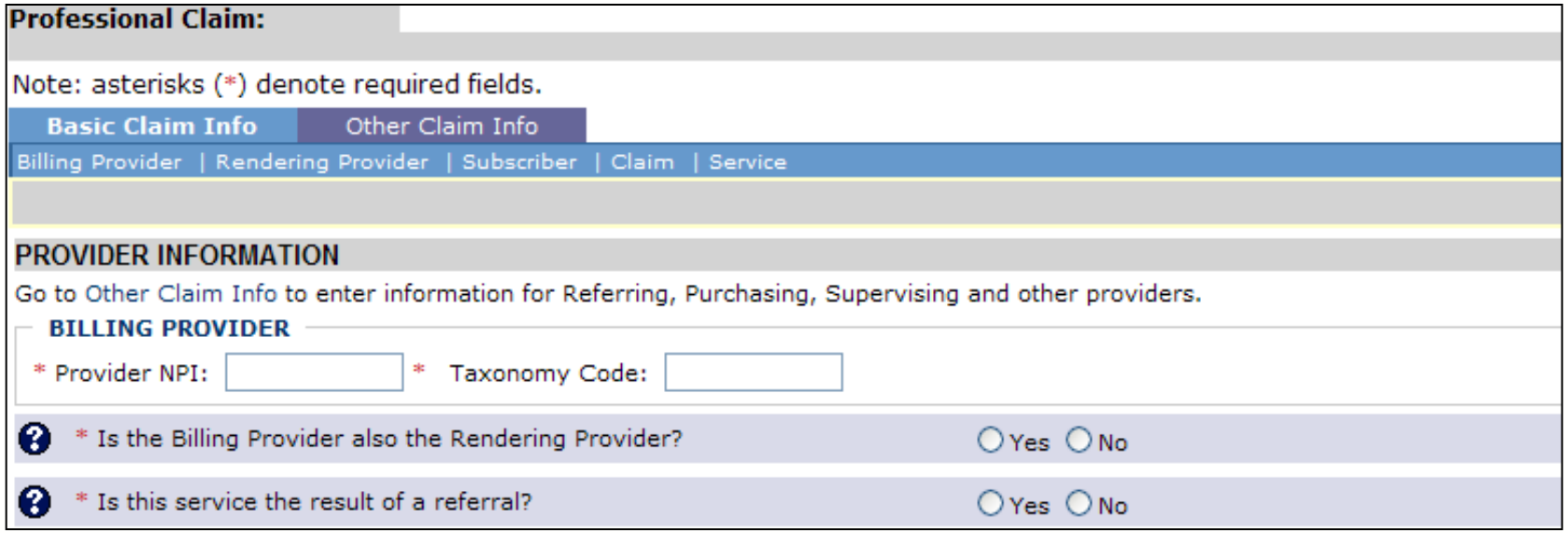
Direct Data Entry Claims (DDE)



Washington State Health Care Authority

Billing Provider Information

- Section 1: Billing Provider Information of the DDE Professional claim form

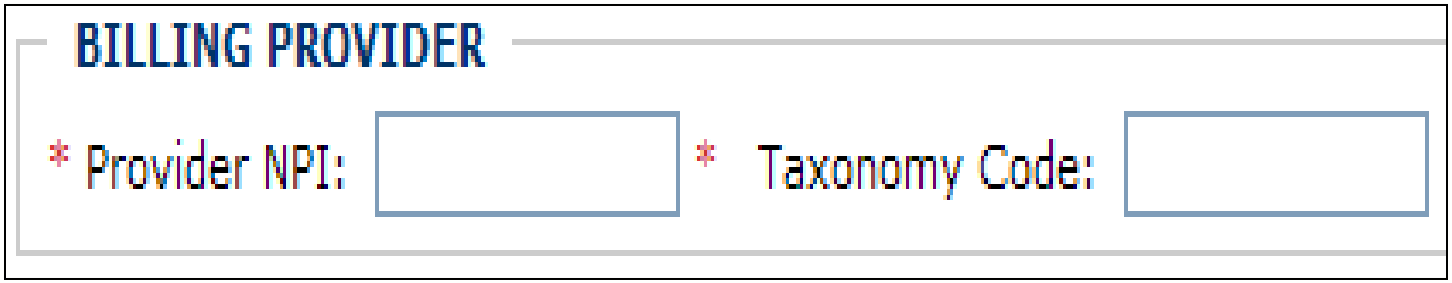


Washington State Health Care Authority

Billing Provider Information

- Enter the Billing Provider NPI and taxonomy code

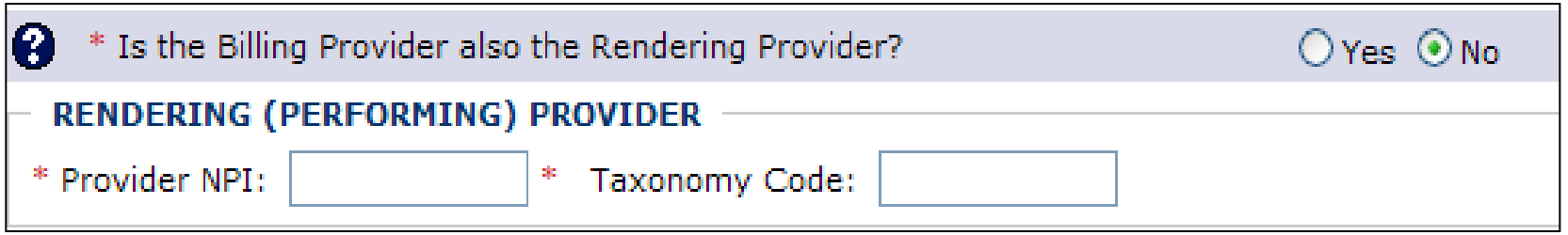
  ✓ This will likely be the NPI and Taxonomy Code of the clinic/office where the service was performed and where you would like payment to be received.



Rendering Provider Information

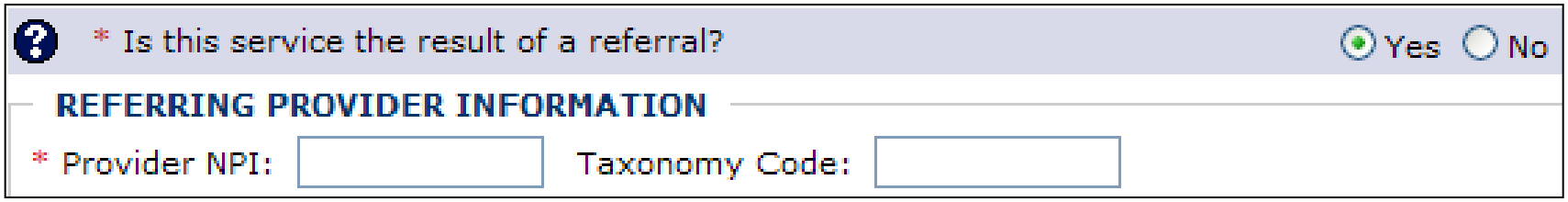
- If the **"Rendering Provider"** is the same as the **"Billing Provider"** you just entered answer the question **"YES"** and go on to the next question.

- If the **"Rendering Provider"** is different than the **"Billing Provider"** you entered in the previous question, answer **"NO"** and enter the **"Rendering (Performing) Provider"** NPI and Taxonomy Code.



Referring Provider Information

- If the service **"Is"** a result of a referral answer **"Yes"** to this question and add the referring provider NPI.

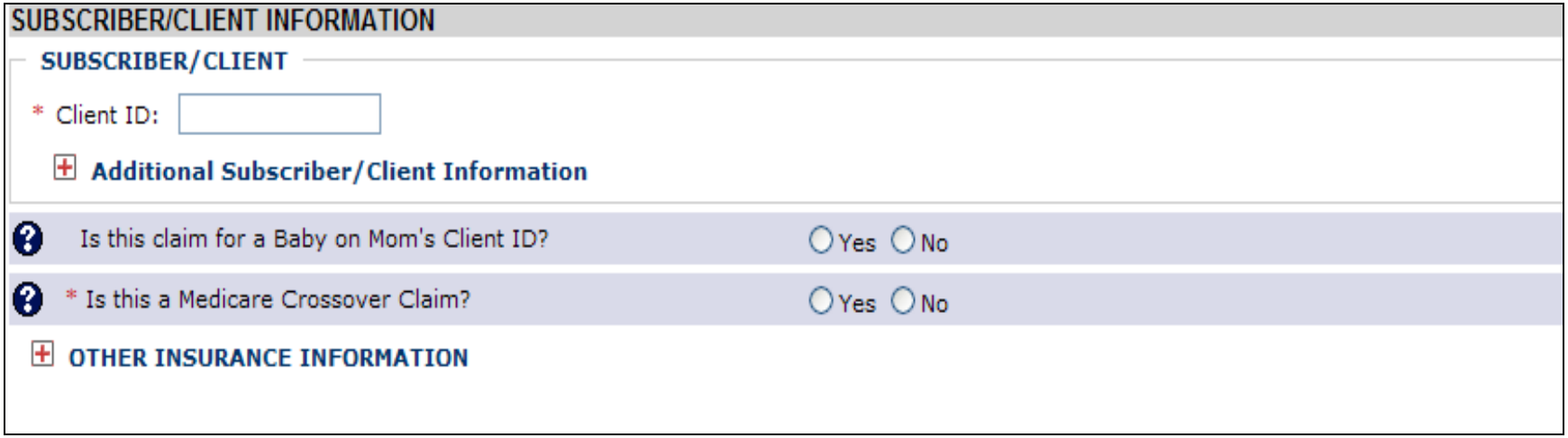


- **Note:** Only the provider NPI number is required for referring providers

- If the service is **"Not"** the result of a referral answer the question **"No"** and continue on to next section.

Subscriber/Client Information

- Section 2: Subscriber/Client Information



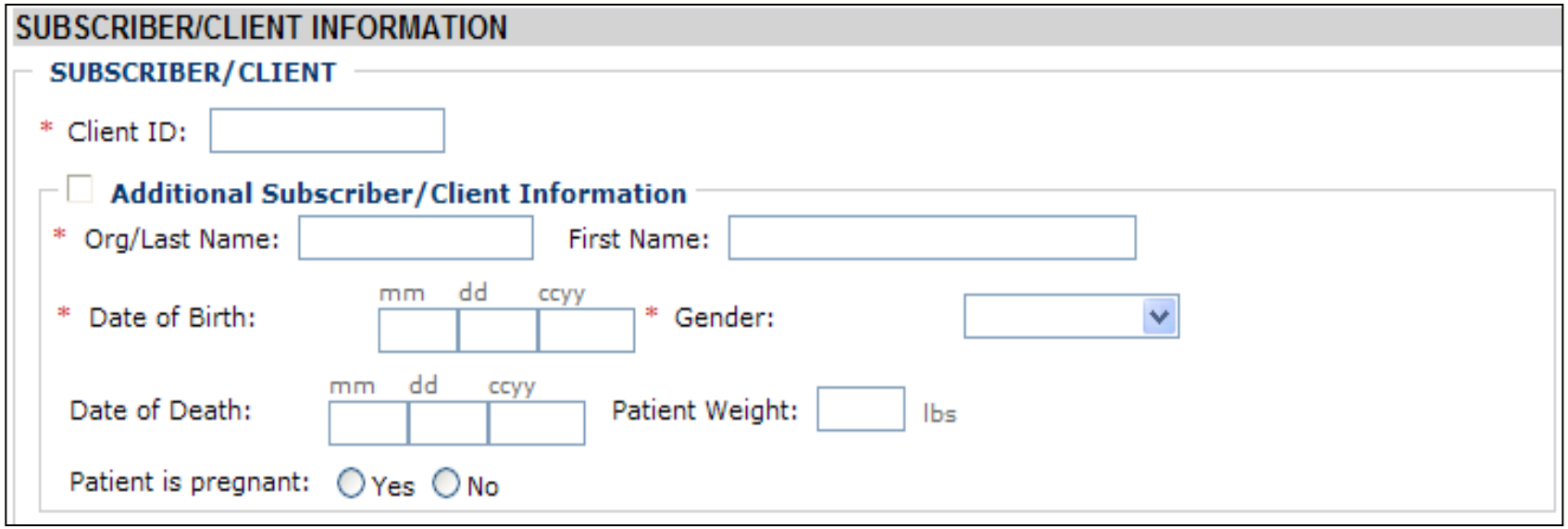
Subscriber/Client Information

- Enter the Subscriber/Client ID found on the WA Medicaid medical card. This ID is a 9 digit number followed by a **"WA"**
  - ✓ Example: 123456789WA

- Click on the red **"+"** to expand the **"Additional Subscriber/Client Information"** to enter required information.

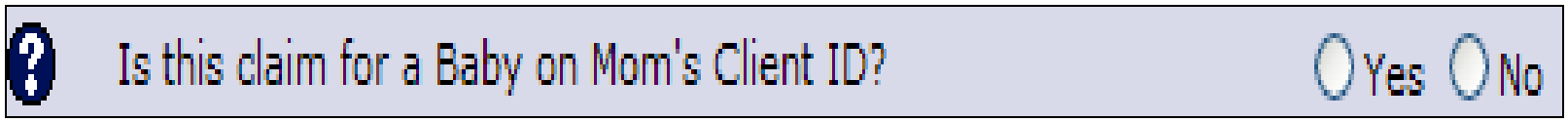
Subscriber/Client Information

- Once the field is expanded enter the **"Patient's Last Name, Date of Birth, and Gender"**.
  - ✓ Date of birth must be in the following format: **MM/DD/CCYY**.
  - ✓ Additional shown information fields are not needed.



Baby on Mom's Client ID

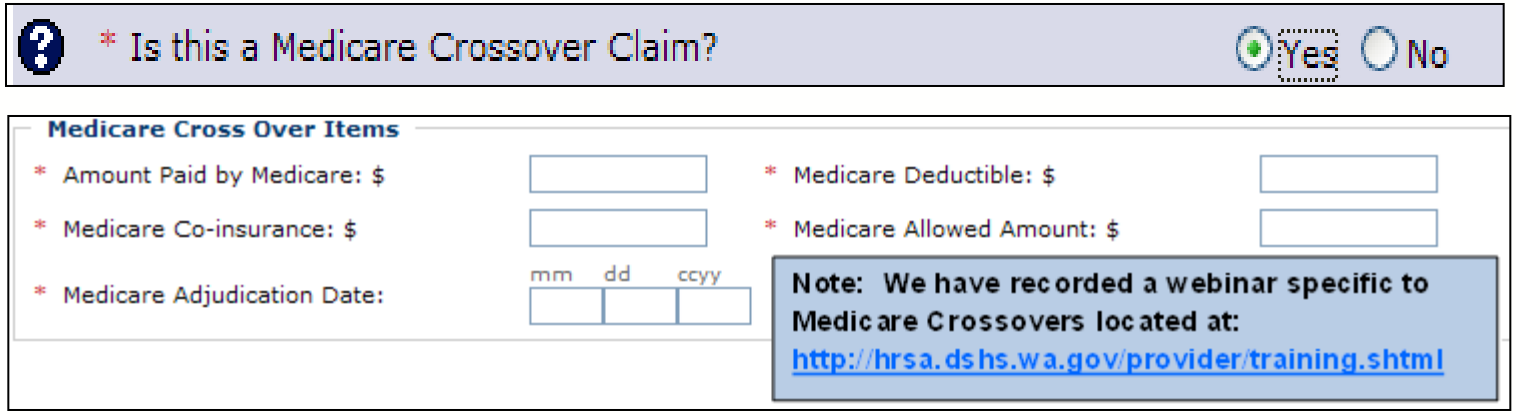
- If claim is for a baby being billed under the mom's ID select **"Yes"** otherwise choose **"No"** and continue to next question.



- **Note:** If claim is for a baby using the mom's ID, use the baby's last name, the baby's date of birth, and gender when filling out the **"Subscriber/Client"** information on previous slide. Be sure to add the claim note **SCI=B** when billing for a baby using mom's ID.

Medicare Crossover Claim

- If the claim is considered a Medicare Crossover answer the question **"YES"**, this includes Managed Medicare Advantage Plans (Medicare Part C)



- **Note:** WA Medicaid considers a claim as a crossover when Medicare allows the service. If Medicare makes a payment, a co-pay/coinsurance should be indicated or if the charges are applied to a deductible, Medicare may not make any payment.

- If Medicare did not make a payment answer the question **"NO"**

Insurance Other Than Medicaid

- If the client has other commercial insurance open the **"Other Insurance Information"** section by clicking on the red **(+)** expander.

- Then open up the **"1 Other Payer Insurance Information"** section by clicking on the red **(+)** expander.

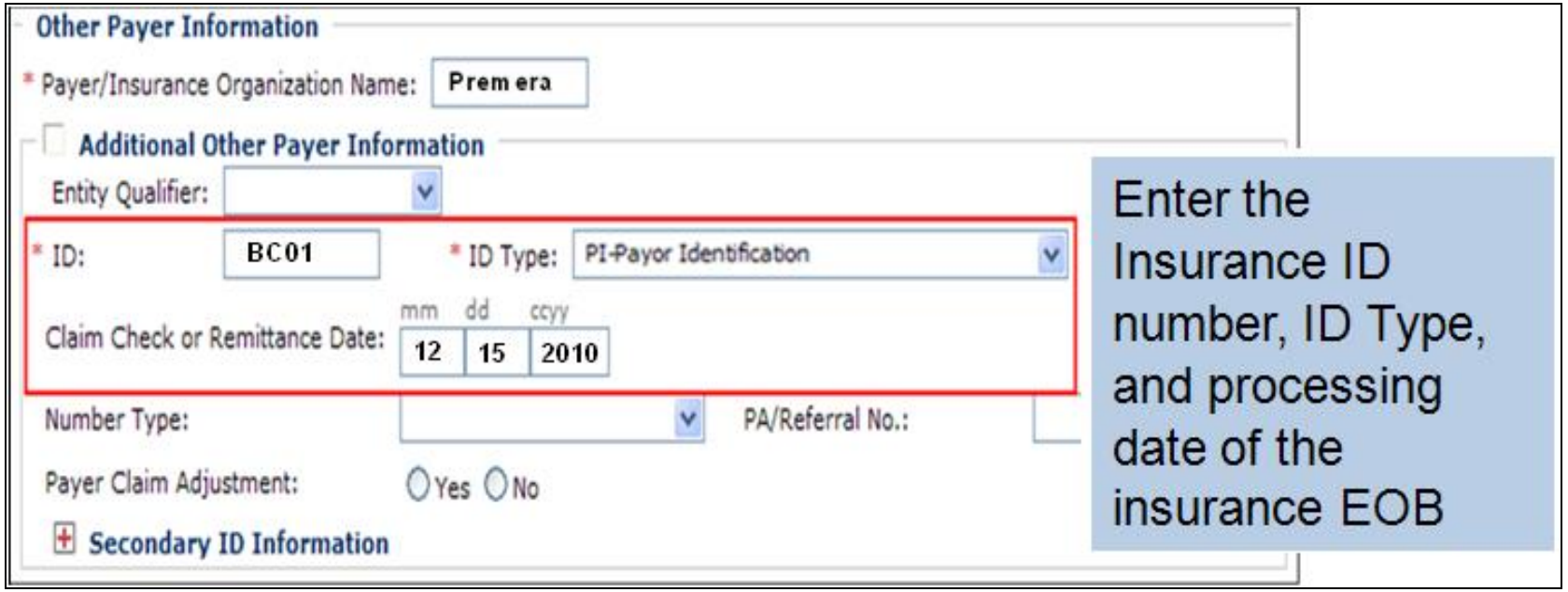
Insurance Other Than Medicaid

- Enter the **"Payer/Insurance Organization Name"** then

- Open up the **"Additional Other Payer Information"** section by clicking on the red **(+)** expander.

Insurance Other Than Medicaid

- In the **"Additional Other Payer Information"** section fill in the following:



Washington State Health Care Authority

Insurance Other Than Medicaid

- Use the Insurance Carrier Code found on the client eligibility screen under the **"Coordination of Benefits"** section as the **"ID"** number for the insurance company, or

- Use the assigned insurance company ID provided on the insurance EOB

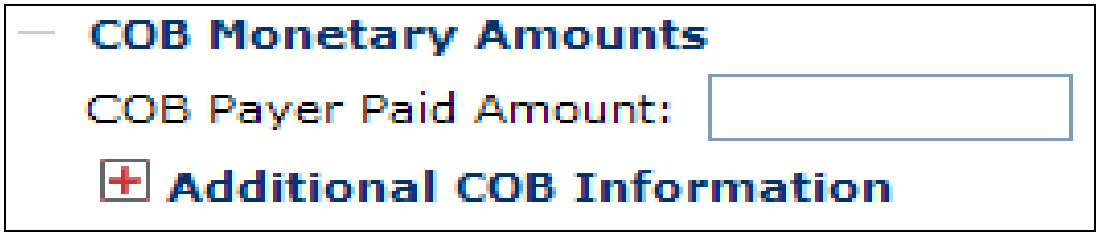
Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	PREMERA BLUE CROSS/BCBS OF AK (800) 345-6784	BC01	SUPER MAN	100883158			03/01/2007	12/31/2999

- See the list of carrier codes at web page http://hrsa.dshs.wa.gov/Download/hcarrier.txt

Insurance Other Than Medicaid

- Enter the total amount paid by the commercial private insurance.

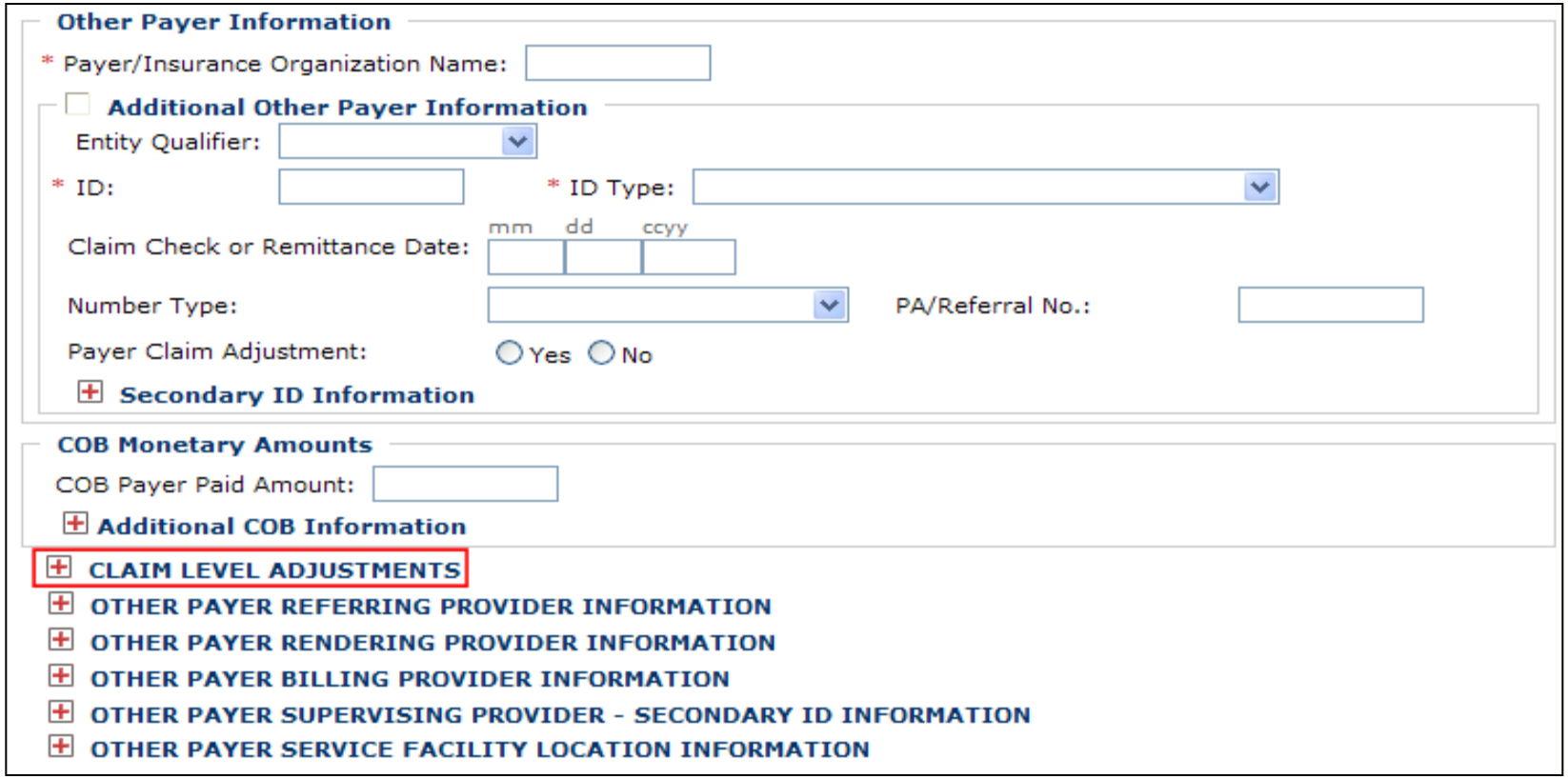


Note: If the insurance applied to the deductible enter a $0 here.

Note: If the claim is for an insurance denial enter a $0 here.

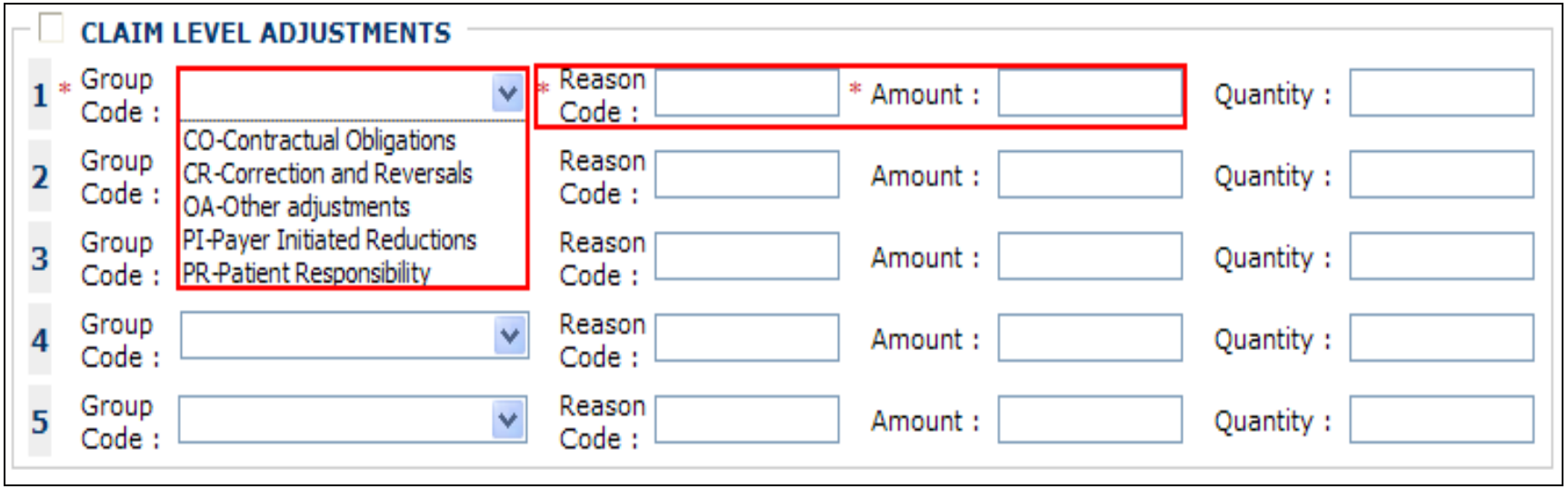
Insurance Other Than Medicaid

- Click on the red **"+"** to expand the **"Claim Level Adjustments"** section.



Insurance Other Than Medicaid

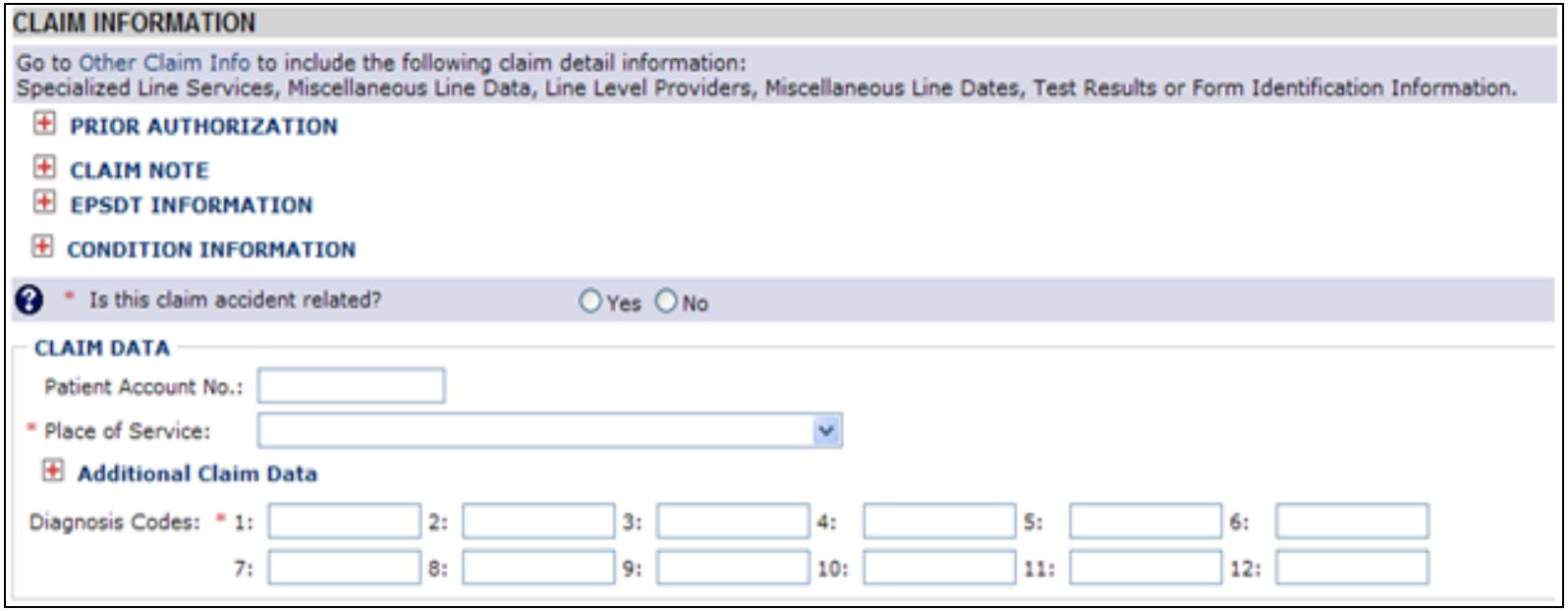
- Enter the adjustment **"Group Code", "Reason Code"** (Number Only), and **"Amount"**



Note: The Agency only accepts the standardized HIPAA compliant group and reason codes. These can be located at the following website: http://www.wpc-edi.com/reference/

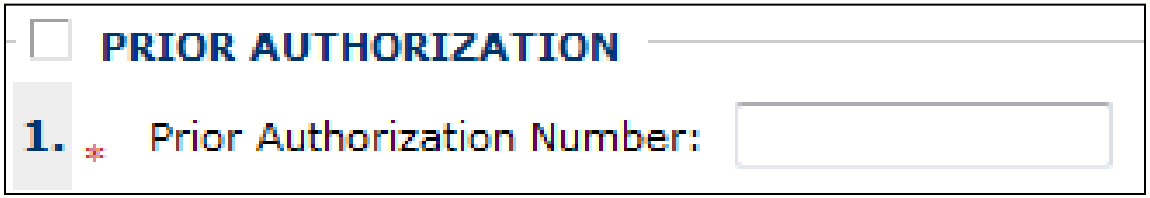
Claim Information

- Section 3: Claim Information Section



Prior Authorization

- If a **"Prior Authorization"** number needs to be added to the claim, click on the red **"+"** to expand the **"Prior Authorization"** fields.
- Expedited Prior Authorization (EPA) numbers are considered authorization numbers and should be entered here.

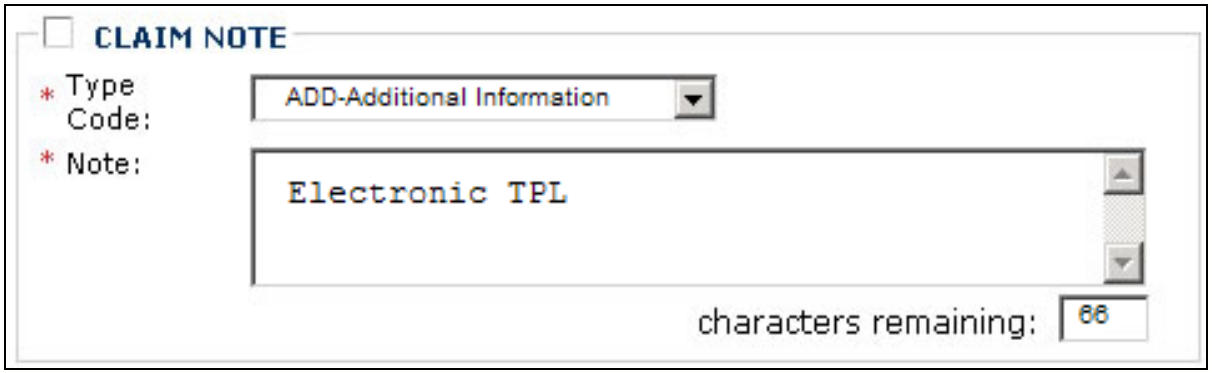


- Note: We recommend that providers enter any authorization number in these boxes. Entering the number here will cover the entire claim.

Claim Note

- A note may to be added to the claim to assist in the processing.

- Click on the red **"+"** to expand the **"Claim Note" section.**
  - ✓ Enter the type Code **"ADD-Additional Information"**.
  - ✓ The note must say **"Electronic TPL"** if no EOB is sent.
  - ✓ The note could say **"Sending ins. EOB"** if the EOB is sent
  - ✓ ProviderOne allows up to 80 characters.

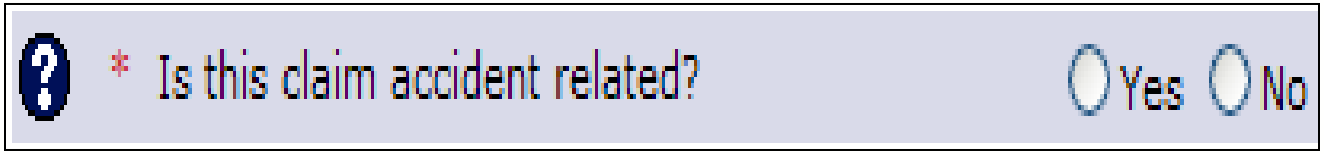


Washington State Health Care Authority

Is the Claim Accident Related?

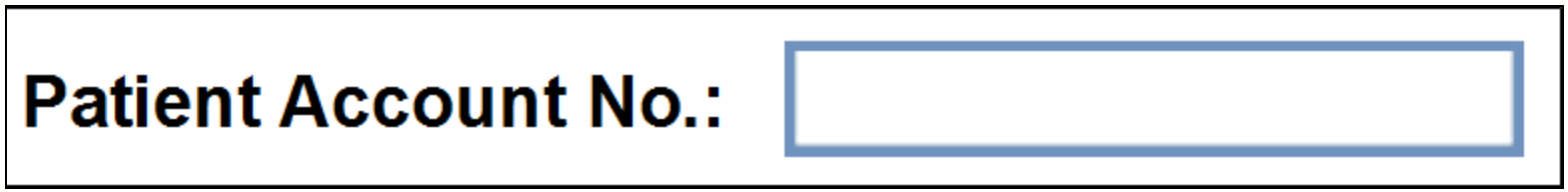
- This question will always be answered **"NO"** as Washington Medicaid has a specific casualty office that handles claims where another casualty insurance may be primary.

  - ✓ The Casualty office can be reached at 1-800-562-3022 extension 15462



Patient Account Number

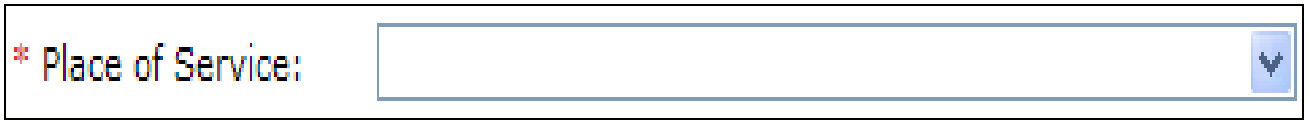
- The **"Patient Account No."** field allows the provider to enter their internal patient account numbers assigned to the patient by their practice management system.



- Note: Entering internal patient account numbers may make it easier to reconcile the weekly remittance and status report (RA) as these numbers will be posted on the RA.

Place of Service

- With 5010 implementation the **"Place of Service"** box has been added to the main claim section. Choose the appropriate **"Place of Service"** from the drop down.



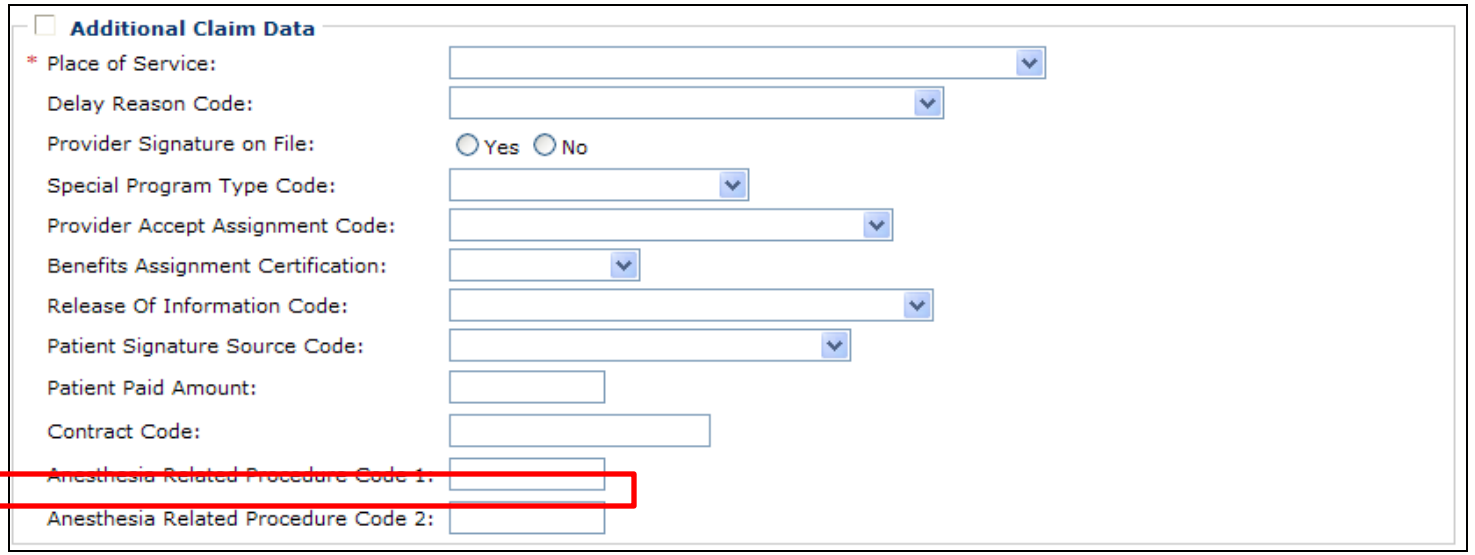
01-PHARMACY
03-SCHOOL
04-HOMELESS SHELTER
05-INDIAN HLTH SVC FREE-STANDING FACILITY
06-INDIAN HLTH SVC PROVIDER-BASED FACILITY
07-TRIBAL 638 FREE-STANDING FACILITY
08-TRIBAL 638 PROVIDER-BASED FACILITY
09-PRISON/CORRECTIONAL FACILITY
11-OFFICE
12-Home
13-ASSISTED LIVING FACILITY
14-Group Home
15-MOBILE UNIT
16-TEMPORARY LODGING
17-WALK-IN RETAIL HEALTH CLINIC
20-URGENT CARE FACILITY
21-INPATIENT HOSPITAL
22-OUTPATIENT HOSPITAL
23-EMERGENCY ROOM - HOSPITAL
24-AMBULATORY SURGICAL CENTER
25-BIRTHING CENTER
26-MILITARY TREATMENT FACILITY
31-SKILLED NURSING FACILITY (SNF)
32-NURSING FACILITY
33-CUSTODIAL CARE FACILITY
34-Hospice
41-AMBULANCE - LAND
42-AMBULANCE - AIR OR WATER
49-INDEPENDENT CLINIC
50-FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
51-INPATIENT PSYCHIATRIC FACILITY
52-PSYCHIATRIC FACILITY - PARTIAL HOSPITALIZATION
53-COMMUNITY MENTAL HEALTH CENTER
54-INTERMEDIATE CARE FACILITY (ICF/MR)
55-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
56-PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
57-NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
60-MASS IMMUNIZATION CENTER
61-COMPREHENSIVE INPATIENT REHAB FACILITY
62-COMPREHENSIVE OUTPATIENT REHAB FACILITY
65-END-STAGE RENAL DISEASE TREATMENT FACILITY
71-PUBLIC HEALTH CLINIC
72-RURAL HEALTH CLINIC (RHC)
81-INDEPENDENT LABORATORY
99-OTHER PLACE OF SERVICE

- Note: The **"Place of Service"** is required in this section but can still be added to the line level of the claim. Line level is **not** required.

Additional Claim Data

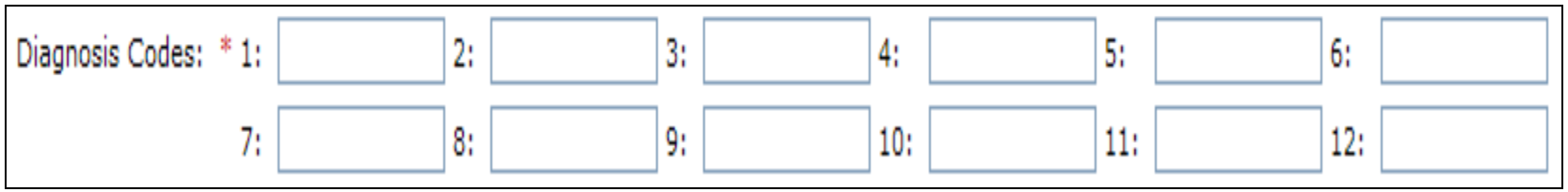
- The **"Additional Claim Data"** red **(+)** expander will allow the provider to enter the patient's spenddown amount.

- If patient has a spenddown click on the red **(+)** expander to display the below image. Enter the spenddown amount in the **"Patient Paid Amount"** box.



Diagnosis Codes

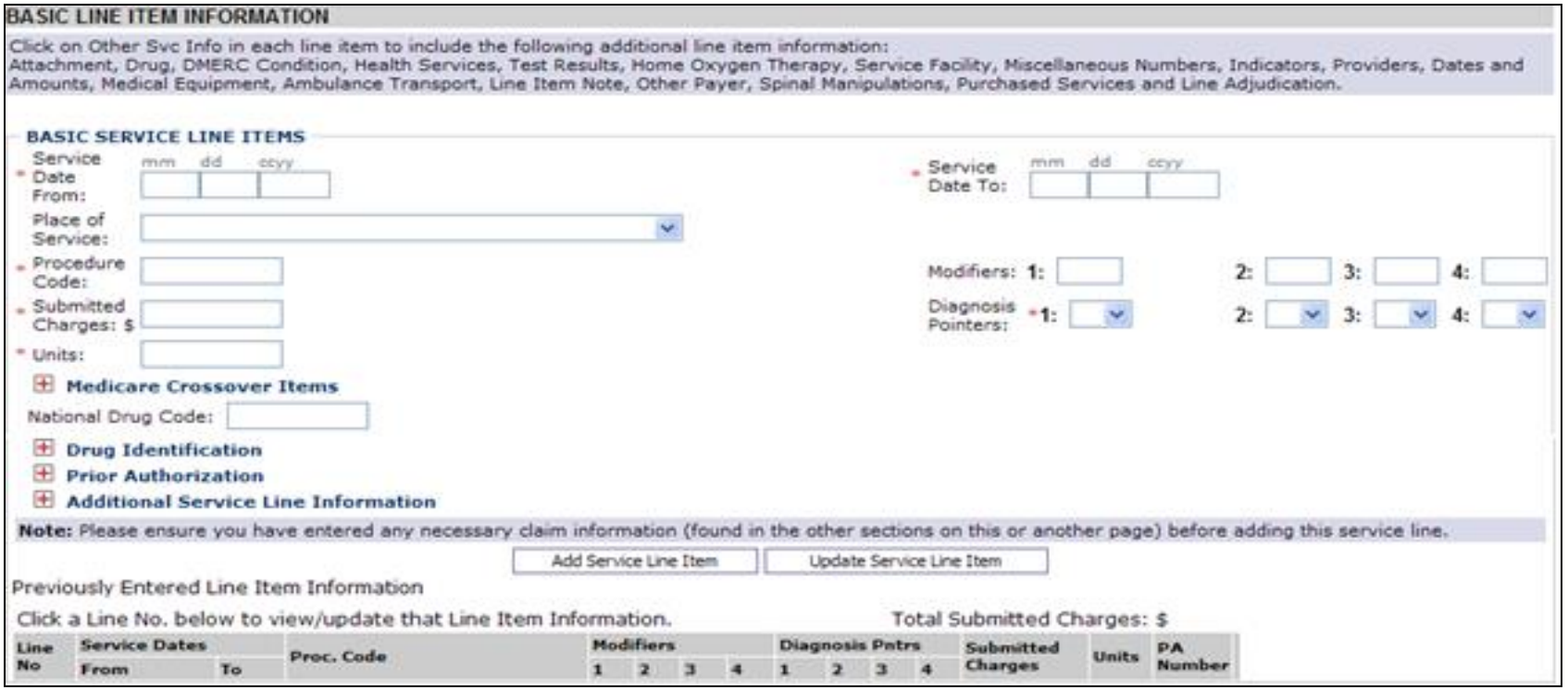
- Enter the appropriate ICD-9 diagnosis code or codes.



- Note:
  - ✓ At least 1 diagnosis code is required for all claims.
  - ✓ ProviderOne will allow up to 12 ICD-9 diagnosis codes.
  - ✓ Do not enter decimal points in DX codes. ProviderOne will add these in once the claim is submitted.

Basic Service Line Items

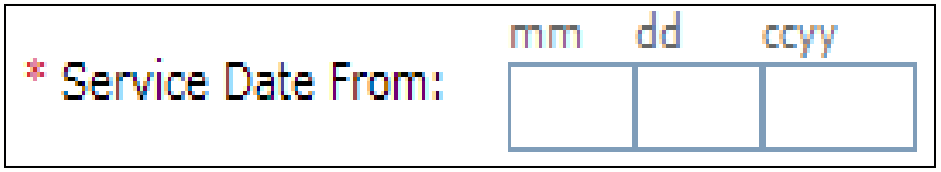
- Section 4: Basic Line Item Information



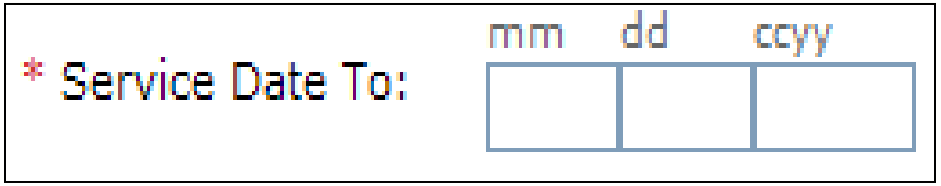
Washington State Health Care Authority

Basic Service Line Items

- Enter the "From Service Date"



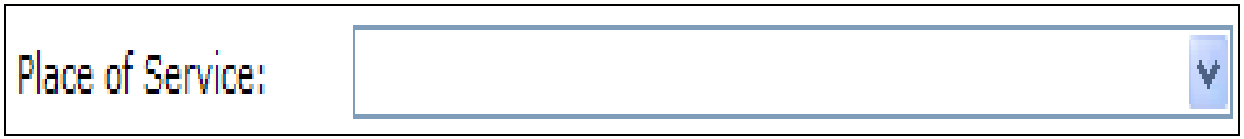
- Enter the "To Service Date"



- Note: The dates of service must be in the format of 2 digit month, 2 digit day, and 4 digit year, for example 10/03/2011.

Basic Service Line Items

- **Optional** "Place of Service Code" (Not required here as already entered)



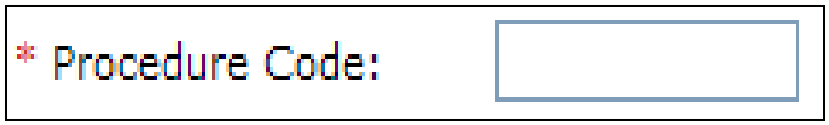
- **Note:** Use the "Blue Arrow" drop down to display all POS codes loaded in ProviderOne.

- POS codes available:

01-PHARMACY	20-URGENT CARE FACILITY	51-INPATIENT PSYCHIATRIC FACILITY
03-SCHOOL	21-INPATIENT HOSPITAL	52-PSYCHIATRIC FACILITY - PARTIAL HOSPITALIZATION
04-HOMELESS SHELTER	22-OUTPATIENT HOSPITAL	53-COMMUNITY MENTAL HEALTH CENTER
05-INDIAN HLTH SVC FREE-STANDING FACILITY	23-EMERGENCY ROOM - HOSPITAL	54-INTERMEDIATE CARE FACILITY (ICF/MR)
06-INDIAN HLTH SVC PROVIDER-BASED FACILITY	24-AMBULATORY SURGICAL CENTER	55-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
07-TRIBAL 638 FREE-STANDING FACILITY	25-BIRTHING CENTER	56-PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
08-TRIBAL 638 PROVIDER-BASED FACILITY	26-MILITARY TREATMENT FACILITY	57-NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
09-PRISON/CORRECTIONAL FACILITY	31-SKILLED NURSING FACILITY (SNF)	60-MASS IMMUNIZATION CENTER
11-OFFICE	32-NURSING FACILITY	61-COMPREHENSIVE INPATIENT REHAB FACILITY
12-Home	33-CUSTODIAL CARE FACILITY	62-COMPREHENSIVE OUTPATIENT REHAB FACILITY
13-ASSISTED LIVING FACILITY	34-Hospice	65-END-STAGE RENAL DISEASE TREATMENT FACILITY
14-Group Home	41-AMBULANCE - LAND	71-PUBLIC HEALTH CLINIC
15-MOBILE UNIT	42-AMBULANCE - AIR OR WATER	72-RURAL HEALTH CLINIC (RHC)
16-TEMPORARY LODGING	49-INDEPENDENT CLINIC	81-INDEPENDENT LABORATORY
17-WALK-IN RETAIL HEALTH CLINIC	50-FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	99-OTHER PLACE OF SERVICE

Basic Service Line Items

- Enter the "Procedure Code"



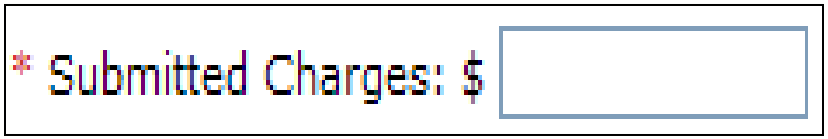
- Note: Use current codes listed in the coding manuals.

- Enter the appropriate procedure **"Modifier(s)"** if needed.

- Note: ProviderOne allows up to 4 Modifiers to be added to a single procedure code.

Basic Service Line Items

- Enter **"Submitted Charges"**

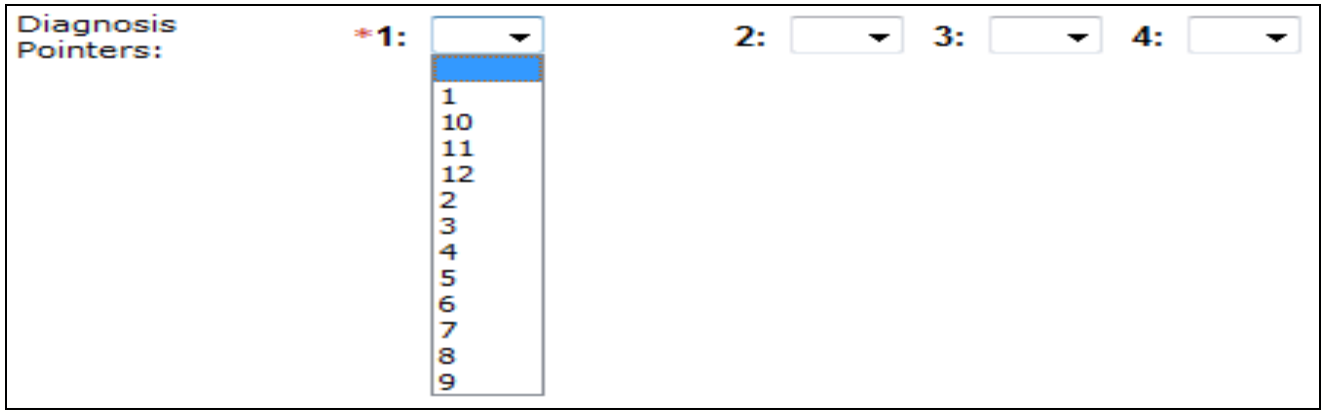


- Note: If dollar amount is a whole number no decimal point is needed.

- Note: The Agency request providers to enter their usual and accustom charges here. If providers have billed a Commercial Insurance or Medicare primary, please enter the same charges here as billed to the primary. If a provider is billing for DME supplies that required prior authorization, please enter the same amount here as was on the authorization request because they must match.

Basic Service Line Items

- Enter appropriate "Diagnosis Pointer"



- Note:
  - ✓ At least one DX pointer is required.
  - ✓ Up to 4 DX codes can be added per service line.
  - ✓ Diagnosis Pointer 1 is the primary DX code.
  - ✓ Diagnosis Pointer drop down corresponds with DX codes entered previously.

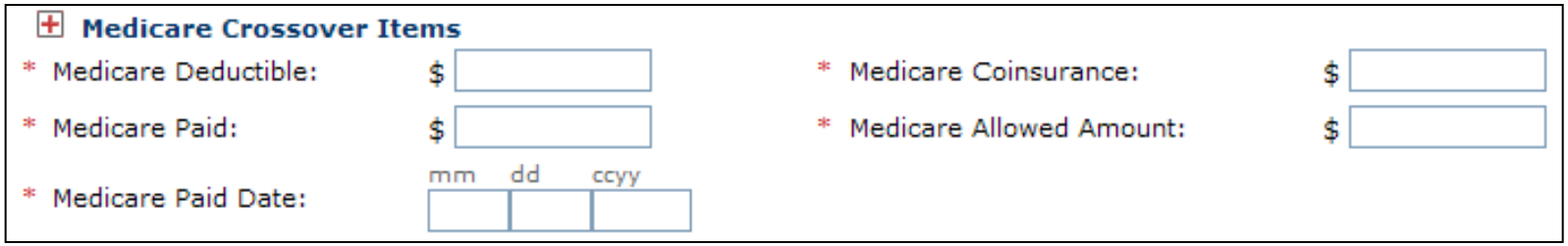
Basic Service Line Items

- Enter procedure "Units"

- Note: At least 1 unit is required

Basic Service Line Items

- If the claim is a "Medicare Crossover" claim complete the following:

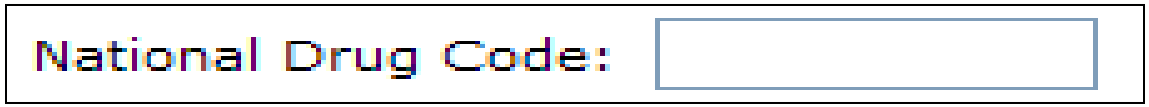


- Note: Entering the line level Medicare information is required here if the previous question concerning Medicare Crossovers was answered yes. The line level Medicare payment data sum must match the claim level Medicare payment data entered.

- Note: For complete instructions on how to submit a Medicare Crossover claim please view the online webinar and presentation slides at http://hrsa.dshs.wa.gov/provider/training.shtml

Basic Service Line Items

- Enter **"National Drug Code"** (NDC) if billing an injectable procedure code.



- The **"Drug Identification"** red **(+)** expander is not needed when billing for injectable procedure codes.

Basic Service Line Items

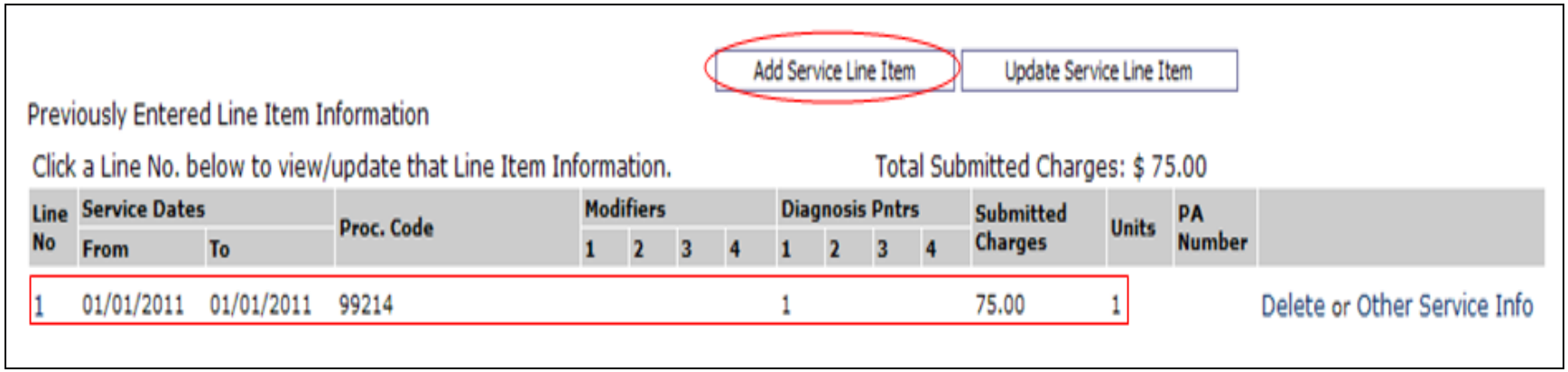
- If a **"Prior Authorization"** number needs to be added to a line level procedure code, click on the red **"+"** to expand the **"Prior Authorization"** option.

- Note: If a Prior Authorization number was entered previously on the claim it is not necessary to enter it again here.

- The **"Additional Service Line Information"** is not needed for claims submission.

Add Service Line Items

- Click on the **"Add Service Line Item"** button to list the procedure line on the claim.

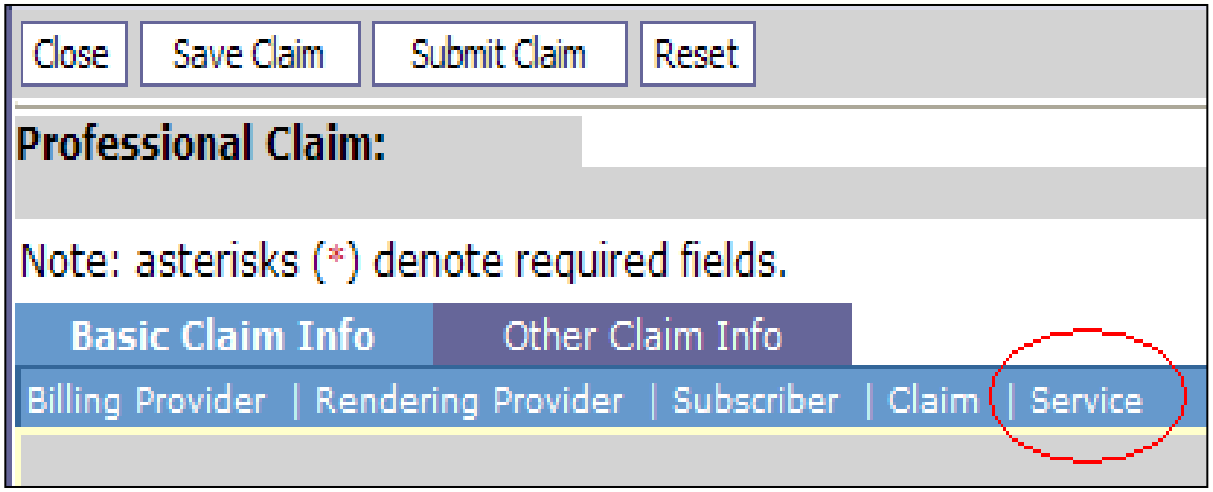


- Note: Please ensure all necessary claim information has been entered before clicking the **"Add Service Line Item"** button to add the service line to the claim.

- Note: Once the procedure line item is added, ProviderOne will refresh and return to the top of the claim form.

Add Additional Service Line Items

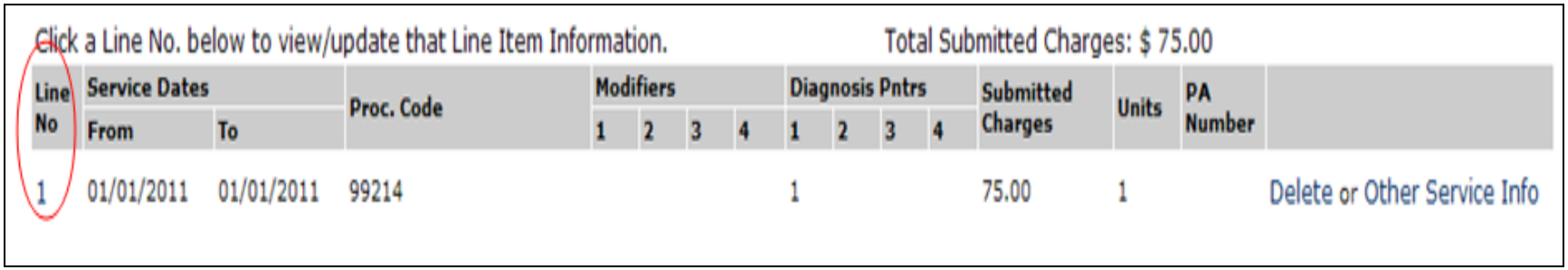
- If additional service lines need to be added, click on the **"Service"** hyperlink to get quickly back to the **"Basic Service Line Items"** section.



- Then follow the same procedure as outlined above for entering data for each line.

Update Service Line Items

- Update a previously added service line item by clicking on the line number of line that needs to be updated. This will repopulate the service line item boxes for changes to be made.



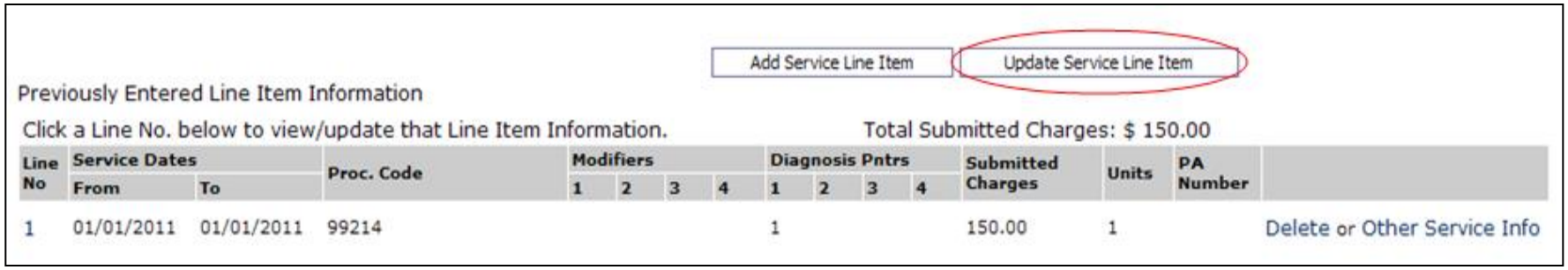
Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 75.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	01/01/2011	01/01/2011	99214					1				75.00	1		Delete or Other Service Info

- Note: Once the line number is chosen, ProviderOne will refresh screen and return to the top of the claim form. Use the "Service" hyperlink to quickly return to the service line item boxes and make corrections.

Update Service Line Items

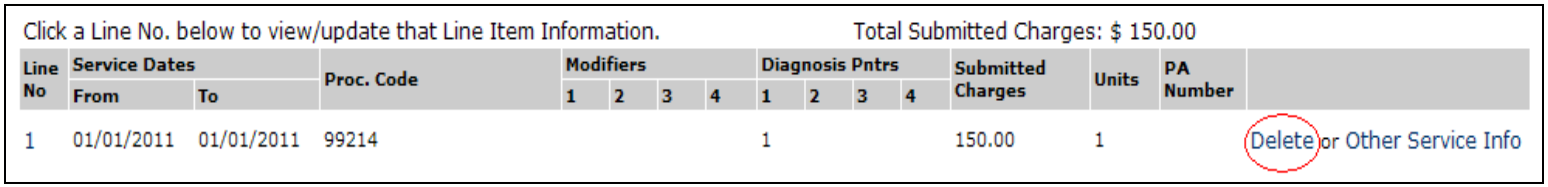
- Once the service line is corrected, click on the **"Update Service Line Item"** button to add corrected information on claim.



- Note: Once the **"Update Service Line Item"** button is chosen, ProviderOne will refresh screen and return to the top of the claim form. Use the **"Service"** hyperlink to quickly return to the service line item section to view and verify that changes were completed.

Delete Service Line Items

- A service line can easily be **"Deleted"** from claim before submission by clicking on the **"Delete"** option at the end of the added service line.



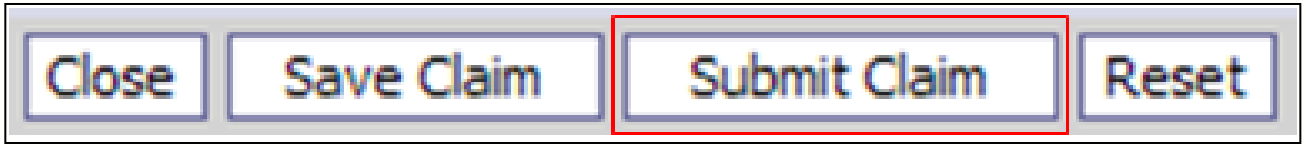
Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 150.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	01/01/2011	01/01/2011	99214					1				150.00	1		Delete or Other Service Info

- Note: Once the service line item is deleted it will be permanently removed from claim. If the service line was accidently deleted the provider will need to re-enter the information following previous instructions.

Submit Claim for Processing

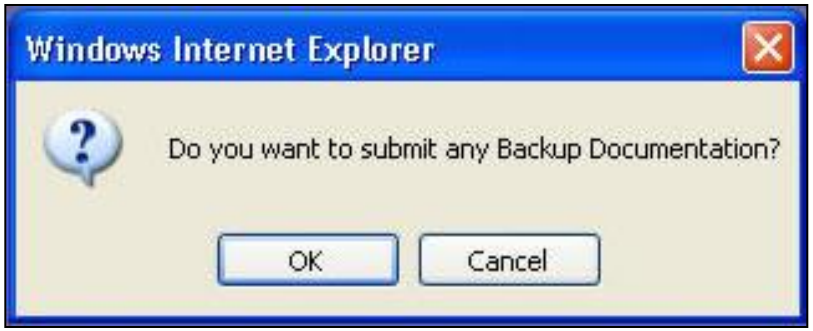
➢ When the claim is ready for processing, click the **"Submit Claim"** button at the top of the claim form.



➢ Note: Make sure the browser **"Pop Up Blocker"** is **OFF** or the system will not allow the claim to be submitted.

Submit Claim for Processing

- After the **"Submit Claim"** button is pushed the following **"Pop Up"** is displayed

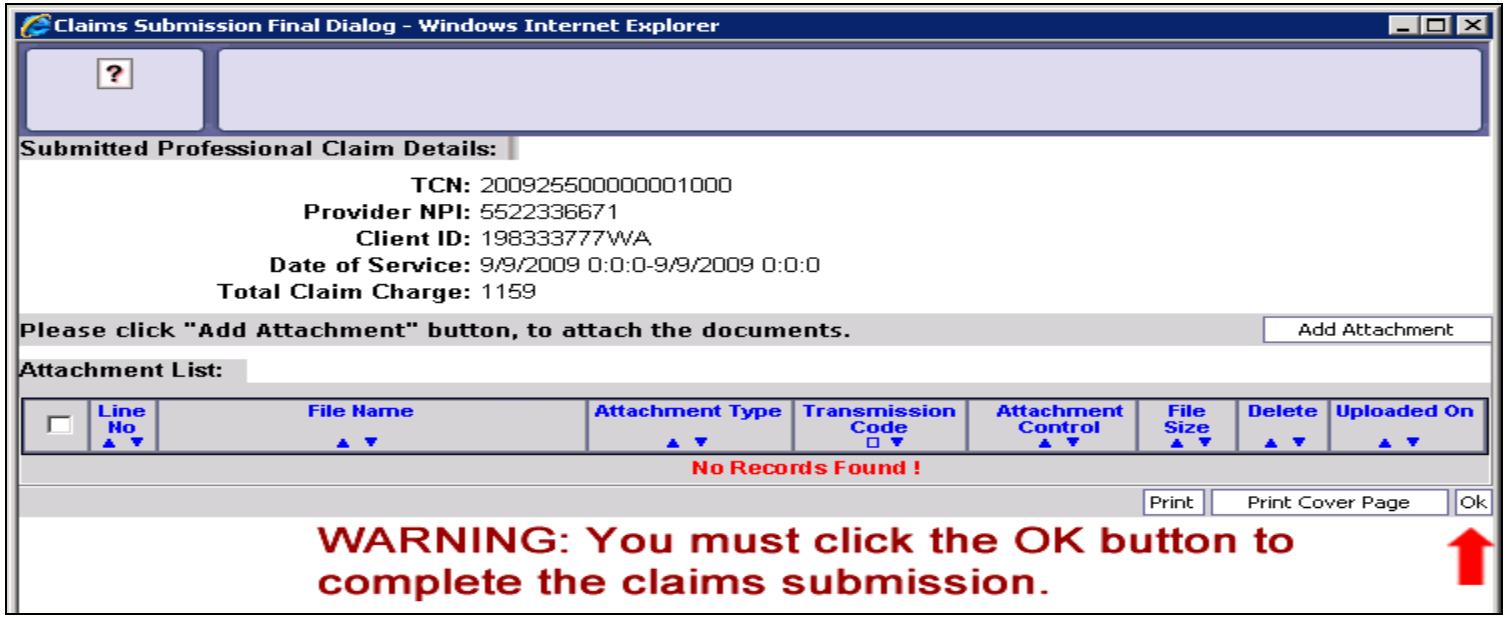


- Click on the **"Cancel"** button if no backup is to be sent.
- Click on **"OK"** if backup needs to be attached.

- Note: If all insurance information has been entered on the claim, it is not necessary to send the insurance EOB with the claim.

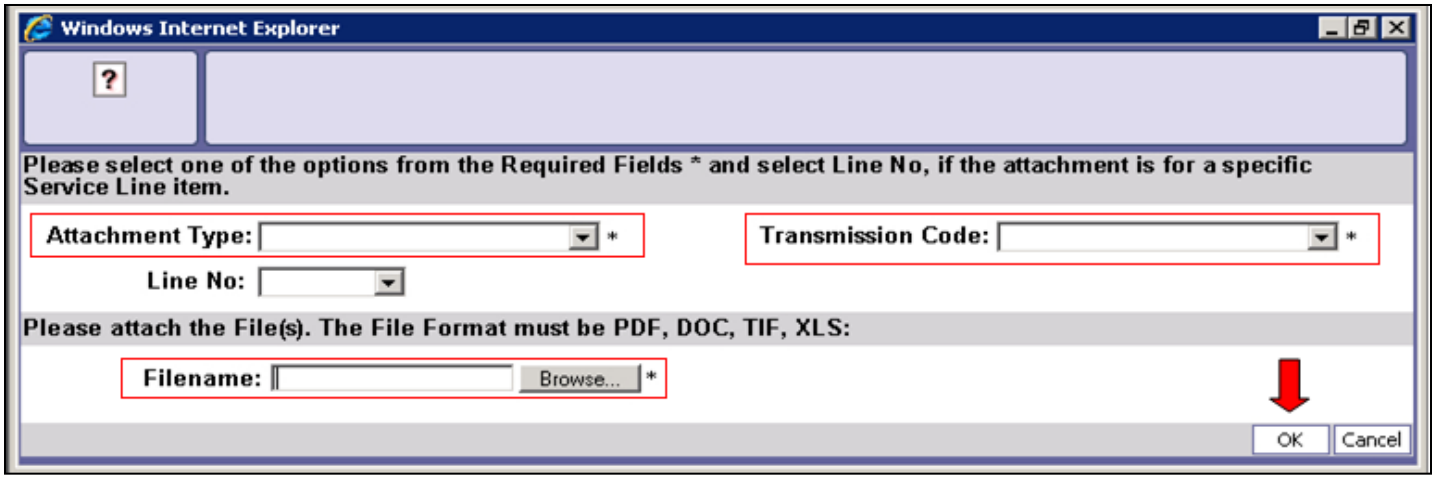
Submit Claim for Processing – No Backup

- ProviderOne now displays the "Submitted Professional Claim Detail" screen
- Click on the "OK" button to finish submitting the claim



Submit Claim for Processing – With Backup (Electronic File Attached)

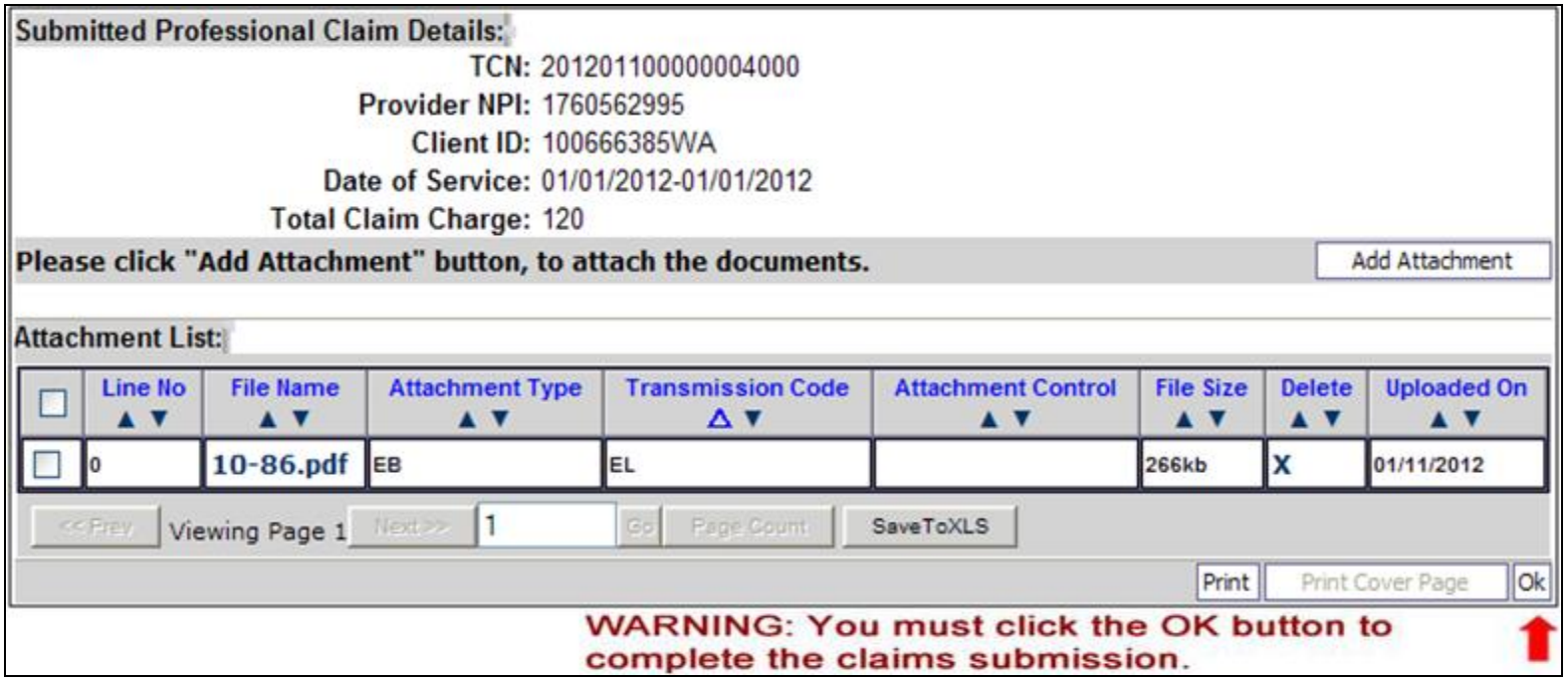
- The **"Claims Backup Documentation"** page is displayed



- ✓ Enter the Attachment Type
- ✓ Pick one of the following Transmission Codes:
  - •EL-Electronic Only or Electronic file,
  - •Then browse to find the file name
- ✓ Click the **"OK"** button

Submit Claim for Processing – With Backup (Electronic File Attached)

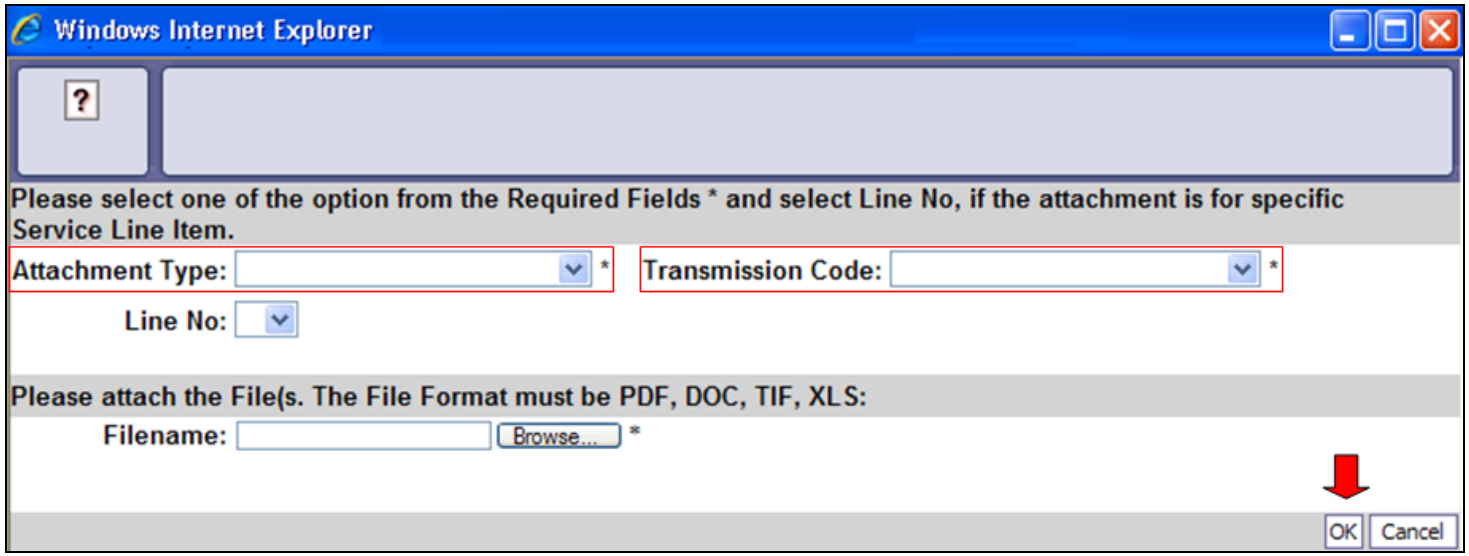
- The **"Submitted Professional Claim Details"** page is then displayed.



- Now push the **"OK"** button to submit the claim.

Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

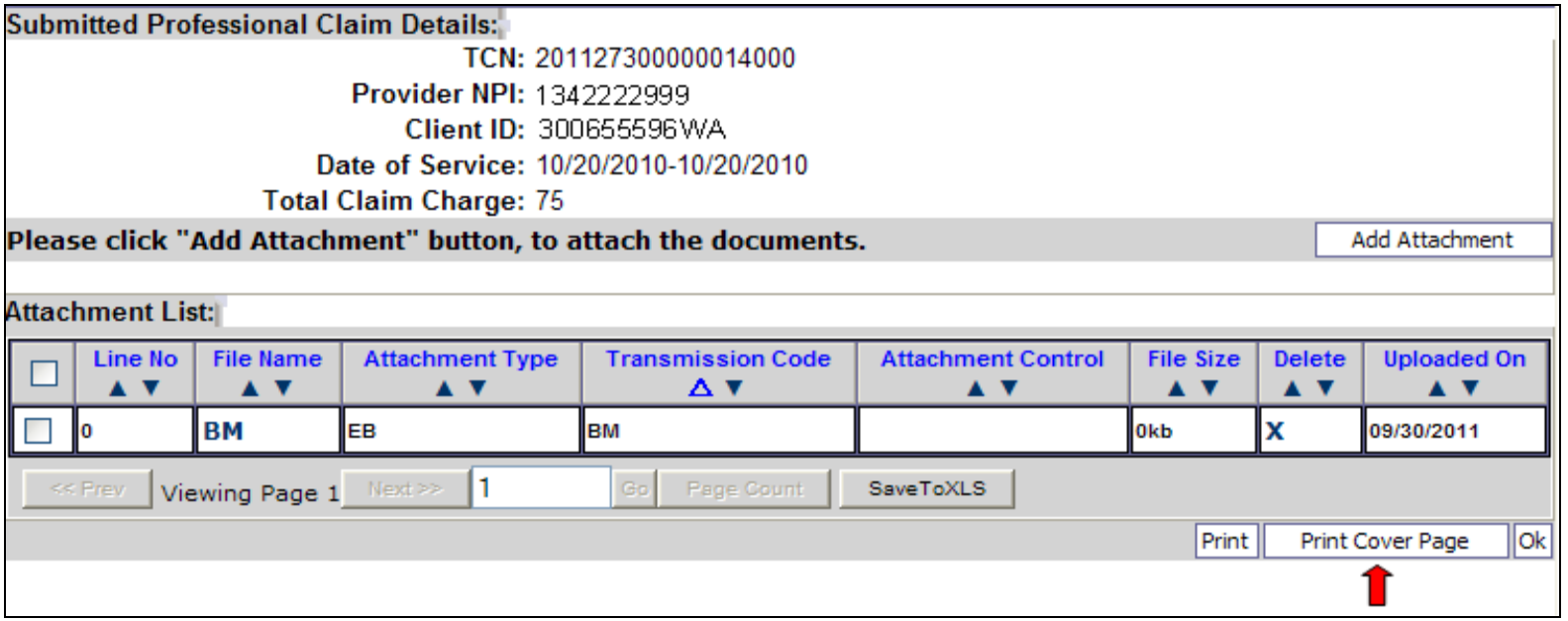
- The **"Claims Backup Documentation"** page is displayed.



- ✓ Enter the Attachment Type
- ✓ Pick one of the following Transmission Codes:
  - •BM : By Mail
  - •FX : Fax
- ✓ Click the **"OK"** button

Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- If sending paper documents with the claim, at the **"Submitted Professional Claim Details"** page click on the **"Print cover Page"** button.



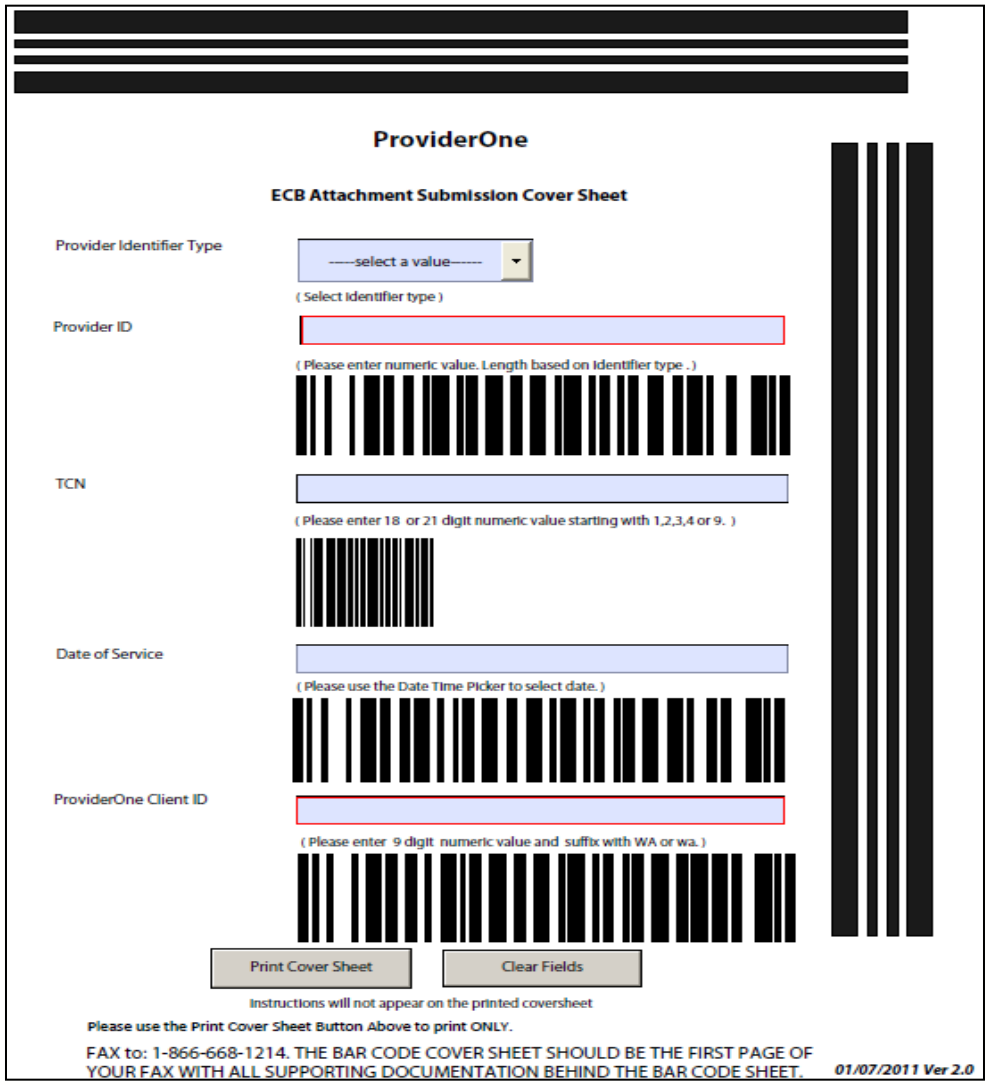
Submit Claim for Processing – With Backup

- Fill in the boxes with the appropriate information. When completed click on the **"Print Cover Sheet"** and mail to:

Electronic Claim Back-up Documentation
PO BOX 45535
Olympia, WA 98504-5535

OR

Fax 1-866-668-1214



ProviderOne

ECB Attachment Submission Cover Sheet

Provider Identifier Type: -----select a value------
(Select identifier type)

Provider ID
(Please enter numeric value. Length based on identifier type .)

TCN
(Please enter 18 or 21 digit numeric value starting with 1,2,3,4 or 9.)

Date of Service
(Please use the Date Time Picker to select date.)

ProviderOne Client ID
(Please enter 9 digit numeric value and suffix with WA or wa.)

Print Cover Sheet | Clear Fields

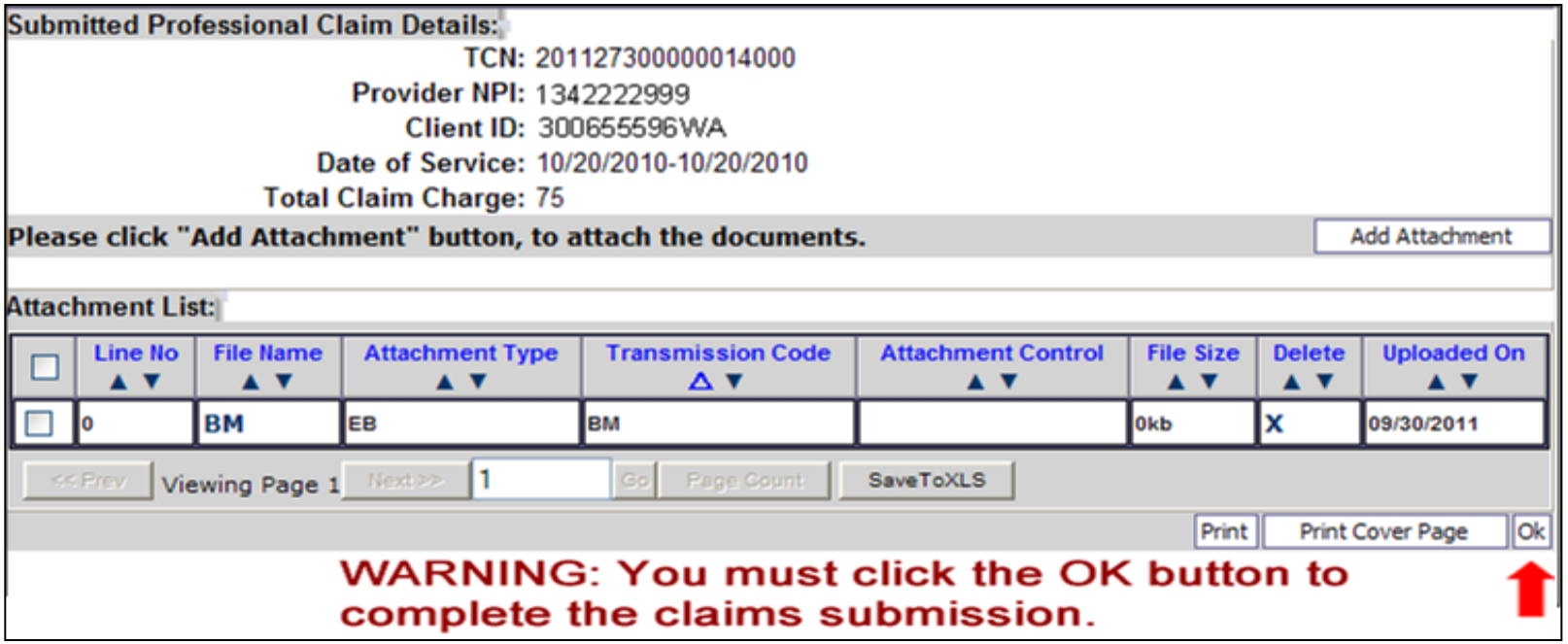
Instructions will not appear on the printed coversheet

Please use the Print Cover Sheet Button Above to print ONLY.

FAX to: 1-866-668-1214. THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET. *01/07/2011 Ver 2.0*

Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- Now push the **"OK"** button to submit the claim



Washington State Health Care Authority

Batch Secondary Electronic Billing

- The Agency is accepting secondary electronic claim billing through a clearinghouse batch or a self submitted HIPAA claim batch.
- Add the required comment "Electronic TPL" in Loop 2300 NTE Segment.
- Add the required Adjustment Reason Code information (Loop information located on the above pages in the companion guides).

Saving a Direct Data Entry (DDE) Claim

Saving a Direct Data Entry Claim

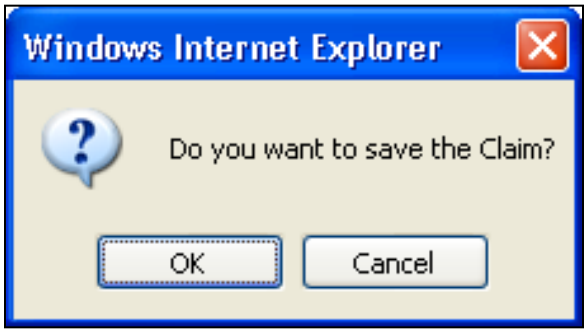
- ProviderOne now allows a provider to save a claim if the provider is interrupted during the process of entering a claim, and allows retrieving that saved claim to finish and submit the claim. The following data elements are at minimum required to be completed before a claim can be saved:

Provider Information • Billing Provider NPI • Billing Provider Taxonomy • Question: Is the Billing Provider also the Rendering Provider? • Question: Is this service the result of a referral?	**Subscriber/Client Information** • Client ID number • Question: Is this a Medicare Crossover Claim?
Claim Information • Question: Is this claim accident related?	**Basic Service Line Items** • Line Items are not required for saving a claim.

Saving a Direct Data Entry Claim

- Save the claim by clicking on the "Save Claim" button.

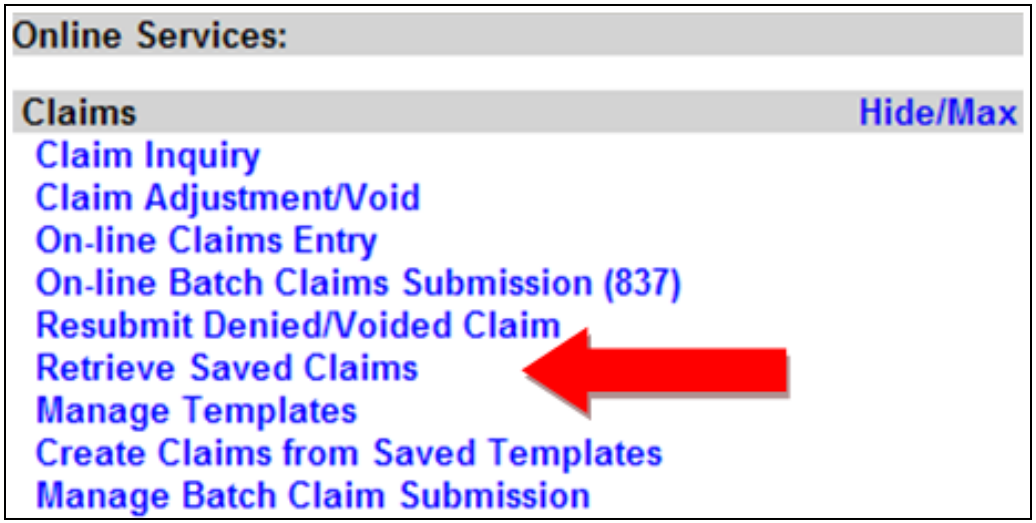
- ProviderOne now displays the following confirmation box:



- Click the **"OK"** button to proceed or Cancel to return to the claim form.
- Once the **"OK"** button is clicked, ProviderOne checks the claim to make sure the minimum data fields are completed.
- If all data fields are completed, ProviderOne saves the claim and closes the claim form.

Retrieving a Saved Direct Data Entry Claim

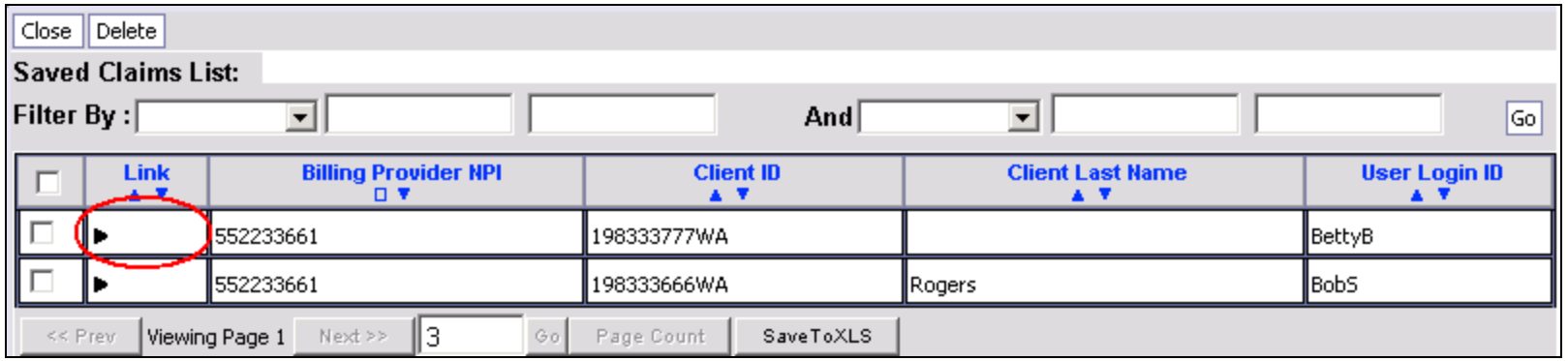
- At the Provider Portal, click on the "Retrieve Saved Claims" hyperlink



Retrieving a Saved Direct Data Entry Claim

- ProviderOne displays the Saved Claims List.

  - ✓ Click on the **"Link"** Icon to retrieve a claim.



- The system loads the saved claim in the correct DDE claim form screen. Continue to enter data, then submit the claim.

- Once a saved claim has been retrieved and submitted, it will be removed from the Saved Claim List.

Medicare Crossover

Medicare Crossover Claims

Learning Objectives:

- After this training, you will be able to:
  - ✓ Verify if a Client has Medicare and determine the type of coverage they have
  - ✓ Bill Medicare crossovers on professional and institutional claim formats electronically
  - ✓ Better understand the Payment Methodology for Medicare parts A, B, and C
  - ✓ Learn tips on billing crossovers successfully

Common Terminology

- Coinsurance
  - ✓ An amount a Medicare client may be required to pay as their share of the cost for services.
- Deductible
  - ✓ The amount for which a beneficiary is responsible before Medicare starts paying.
- Capitated Copayment
  - ✓ A predetermined set dollar amount a Medicare client may be required to pay as their share of the cost for services.
- Non-Capitated Copayment
  - ✓ An amount a Medicare client may be required to pay as their share of the cost for services.

Overview – Medicare Crossover

- There are 4 types of Medicare coverage:
  - ✓ Medicare Part A Inpatient hospital services
  - ✓ Medicare Part B Covers professional and vendor services
  - ✓ Medicare Part C Managed Care version of Medicare, a Medicare Advantage Plan
  - ✓ Medicare Part D Covers prescription drugs
- When is a claim a Medicare Crossover claim?
  - ✓ If Medicare pays or applies to the deductible, the claim billed to HCA is a crossover.
  - ✓ The general rule is to bill the Agency after Medicare on the same claim form billed to Medicare.
  - ✓ The Agency is not paying Part D co-pays. (Part D is not covered in this presentation)

Overview - Medicare Crossovers

- When is a claim **NOT** a crossover claim?
  - ✓ Claims (services) denied by Medicare when billed to us are not crossover claims.
  - ✓ We still require the Medicare EOB to demonstrate non-payment.
- Sometimes Medicare does **NOT** forward claims automatically to the Agency
  - ✓ Can submit in Direct Data Entry or Electronically without the EOMB.
  - ✓ The Medicare Advantage Plans do not cross claim directly so they must be billed as crossover claims.

Overview - Medicare Crossovers

- If Medicare denies a Medical Assistance-covered service that requires Prior Authorization, the service still requires authorization
  - ✓ You may request it after the service is provided.
  - ✓ The Agency waives the "prior" requirement in this circumstance.

Medicare Eligibility

- Eligibility checks may show Medicare as:
  - ✓ QMB – Medicare Only (Qualified Medicare Beneficiary)
    - This program pays for Medicare premiums and may pay deductibles, coinsurance, and copayments according to Medicaid rules.
  - ✓ CNP-QMB (Categorically Needy Program – Qualified Medicare Beneficiary)
    - Client has full Medicaid as well as QMB benefits.

Medicare Eligibility

- Programs that HCA would not consider for secondary payment after Medicare
  - ✓ SLMB (Special Low Income Medicare Beneficiary)
    - This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.
  - ✓ QI-1 (Qualified Individual 1)
    - This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.
  - ✓ QDWI (Qualified Disabled Working Individual) –
    - This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.

Medicare Eligibility

- Determine Medicare eligibility using ProviderOne

Medicare Eligibility Information

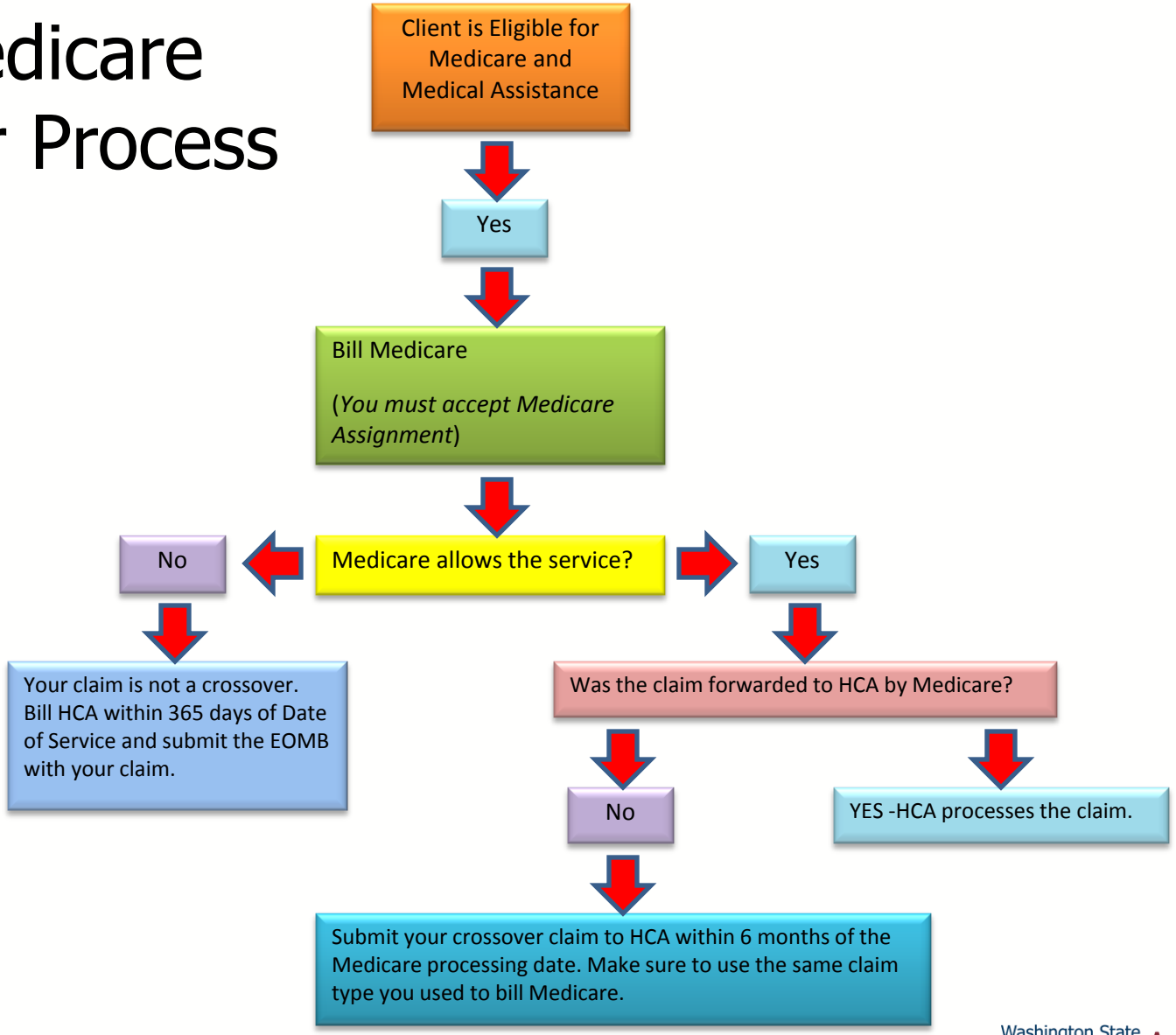
Service Type Code	Insurance Type Code	Eligibility Start Date	Eligibility End Date
30: Health Benefit Plan Coverage	MA: Medicare Part A	01/01/2004	12/31/2999
30: Health Benefit Plan Coverage	MB: Medicare Part B	01/01/2004	12/31/2999

  - ✓ The Medicare HIC number is listed under the "Client Demographic Section"
- Medicare Part C information (if loaded) is located under the COB section

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	RXAMERICA (800) 429-6686	S5644		Med Part D			01/01/2008	12/31/201
30: Health Benefit Plan Coverage	C1: Commercial	STERLING LIFE INSURANCE COMPANY (360) 647-9080	H5006		Med Part C			03/01/2006	12/31/201

The Medicare Crossover Process



Washington State Health Care Authority

Medicare Billing Part B

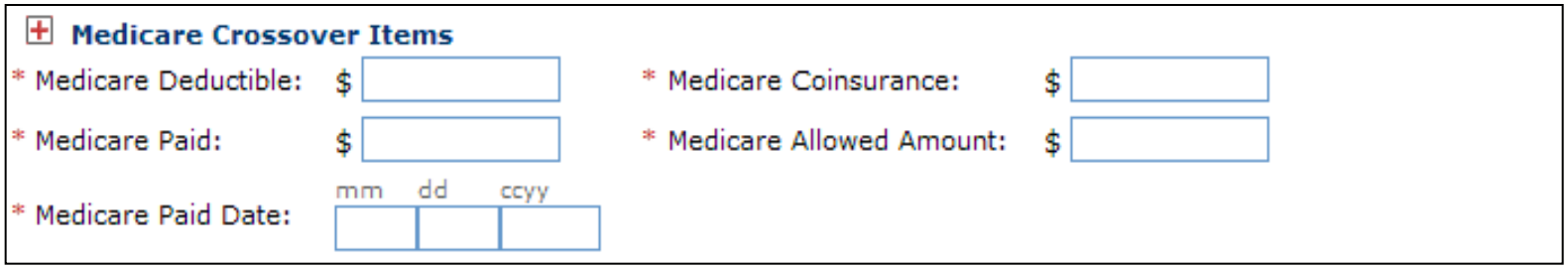
Medicare Billing – Part B

- CMS-1500, 837P
  - ✓ If Medicare has paid all lines on your claim and did not forward the claim to WA Medicaid, submit the crossover claim to the Agency.
  - ✓ If Medicare has allowed and denied service lines on your claim:
    - You will need to submit **TWO** claims to the Agency;
      - One crossover claim for services Medicare paid and;
      - One professional claim for services Medicare denied.

Medicare Billing – Part B

- Bill the Agency using the same service codes and billed amounts sent to Medicare.
- Medicare and Medicare Advantage Plans are Medicare
  - ✓ HCA does not consider Medicare as insurance
- When submitting via Direct Data Entry (DDE)
  - ✓ Click the Radio button **"YES"** to indicate this claim is a crossover

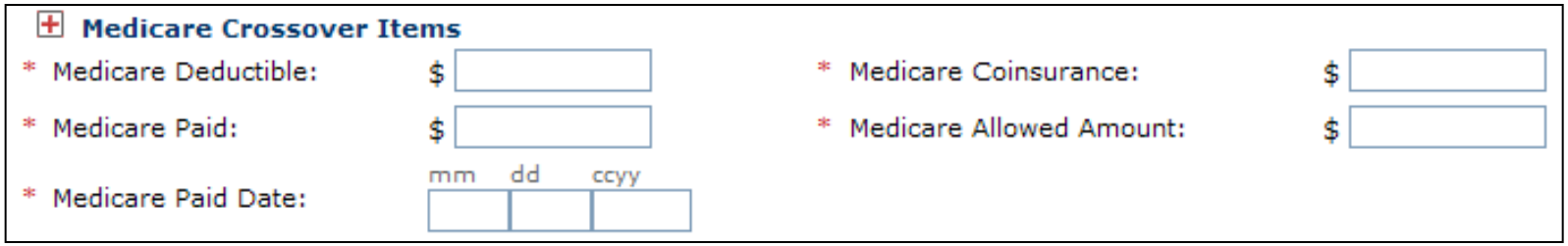
  - ✓ Additional data boxes open to be filled in as required at claim level.



Medicare Billing – Part B

- The rest of claim information is filled out as normal down to the service line information. The Medicare line data must be entered here now.

- **Note:** Entering the line level Medicare information is required if the previous question concerning Medicare Crossovers was answered yes. The line level Medicare payment data sum must match the claim level Medicare payment data entered.



- No EOB is required with the DDE crossover claim.

Medicare Billing – Part B

- HIPAA batch 837P:

Medicare Information

- Loop 2320 – Other Subscriber Information
  - ✓ SBR09 = **MB**

Medicare Payment Information

- Loop 2430 – Coordination Of Benefits
  - ✓ SVD02 = Medicare Paid Amount
  - ✓ CAS01 = PR-Patient Responsibility
  - ✓ CAS02 = 1-Deductible Amount
  - ✓ CAS02 = 2-Coinsurance
  - ✓ DTP03 = Medicare Paid Date (CCYYMMDD)

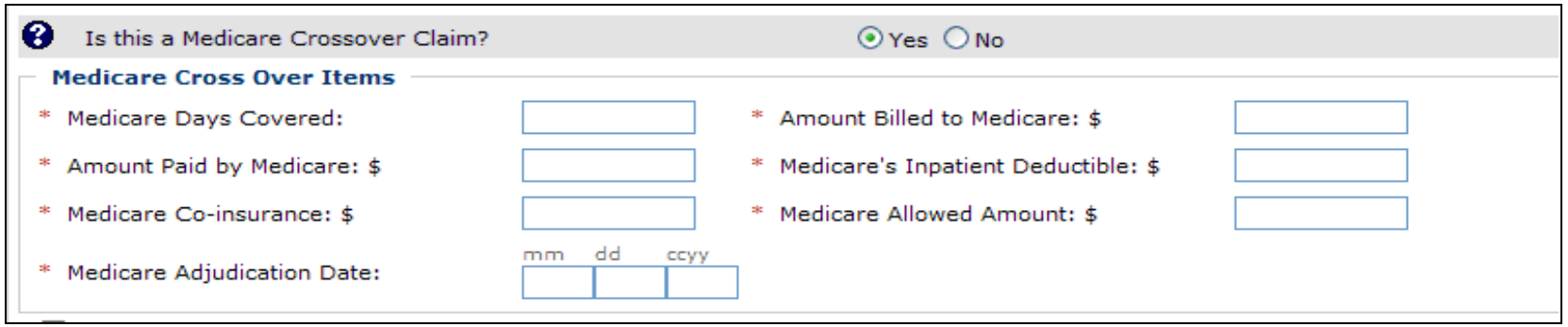
Medicare Billing Part A

Medicare Billing – Part A

- UB-04, 837I
  - ✓ If you bill Medicare using the UB-04 claim format, you would bill the Agency using the same claim format.
  - ✓ Include the same services and billed amounts you sent to Medicare.

RHC note: One date of service per claim form

- Submit DDE crossover claims in ProviderOne
  - ✓ Click Radio button "yes" to indicate claim is a crossover then fill in the data boxes.



Washington State Health Care Authority

Medicare Billing – Part A

- HIPAA batch 837I:

Medicare Information

- ✓ Loop 2320 – Other Subscriber Information
  - SBR09 – **MA** or **MB**

Medicare Payment Information

- ✓ Loop 2320 – Claim Level Adjustment
  - CAS01 = PR-Patient Responsibility
  - CAS02 = 1-Deductible Amount
  - CAS02 = 2-Co-Insurance
- ✓ Loop 2320 – Coordination Of Benefits
  - AMT01 = D-Medicare Amount Paid
- ✓ Loop 2330B – Claim Process Date
  - DTP03 = Medicare Paid Date (CCYYMMDD)

Medicare Billing – Part A

- HIPAA batch 837I:

Medicare Payment Information (continued)

- ✓ Loop 2430 = Claim Level Adjustment
  - SVD02 = Medicare Paid Amount
  - CAS01 = PR-Patient Responsibility
  - CAS02 = 1-Deductible Amount
  - CAS02 = 2-Co-Insurance
  - DTP03 = Medicare Paid Date (CCYYMMDD)

Medicare Billing
Part C

Medicare Billing – Part C

- Some clients have elected to enroll in a Medicare HMO plan called a Medicare Advantage Plan (Part C)
  - ✓ Providers are required to bill the Med Advantage Plans.
  - ✓ Follow the billing guidelines established by the Plans.
- After the Med Advantage plan pays the claim, submit the crossover claim to Medical Assistance.
  - ✓ Bill Medical Assistance on the same claim format.
  - ✓ Make sure the services and billed amounts match what was billed to the Medicare Advantage plan.
  - ✓ No EOMB needed for DDE (it is a crossover claim).
  - ✓ The Agency must receive the Medicare Advantage claim within 6 months of the Medicare Advantage payment date.

Medicare Billing – Part C

- If there is a Capitated Copayment due on claim:
  - ✓ These claims are still billed as crossover claims.
  - ✓ Capitated Copayment crossover claims do not require an EOB.
  - ✓ Comments are no longer required on the claim.
  - ✓ Bill just the Capitated Copayment.
  - ✓ Questions? Detailed instructions for billing are located on page 99 of the *ProviderOne Billing and Resource Guide* located at http://www.hca.wa.gov/medicaid/billing/pages/providerone_billing_and_resource_guide.aspx

Medicare Billing – Part C

- If there is coinsurance, a deductible, or a Non-Capitated Copayment due on a claim.
  - ✓ These claims are billed as crossover claims.
  - ✓ DDE and Electronic crossover claims do not require the EOB with the claim.
  - ✓ Comments are no longer required on the claim.
  - ✓ Questions? Detailed instructions for billing are located on page 99 of the *ProviderOne Billing and Resource Guide* located at http://www.hca.wa.gov/medicaid/billing/pages/providerone_billing_and_resource_guide.aspx

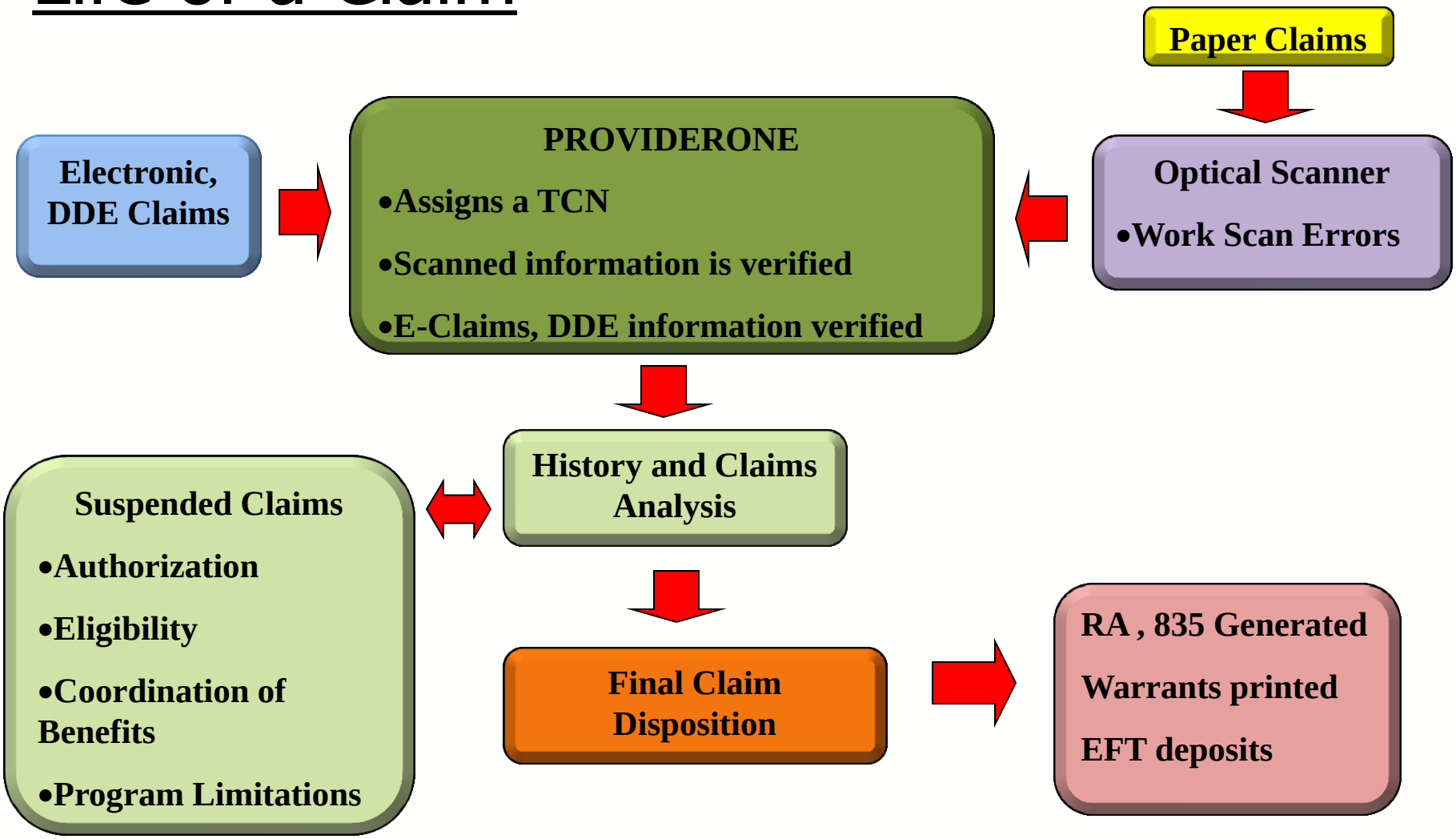
Medicare Billing – Part C

- If the Medicare Advantage Plan does not cover the service
  - ✓ Bill the Agency for the services if the client has Medicaid medical coverage.
  - ✓ The Agency does not pay for the service if the client is only QMB eligible.
  - ✓ Discrepancies, disputes, protests should be directed to the Medicare Advantage plan.
  - ✓ If the Plan adjusts your payment and the crossover claim has been paid, you should adjust the crossover claim.
  - ✓ Submit a new crossover claim if the original claim was denied and the Plan adjustment could result in a payment.

Tips on Billing Crossovers

- Bill your taxonomy code(s) to Medicare the same as you bill your taxonomy code(s) to Medicaid.
- There will be a claim denial due to:
  - ✓ Billing Medicare with an NPI not been reported to the Agency.
    - The Agency will not be able to identify the provider when these claims are forwarded by Medicare.
  - ✓ Billing a paper crossover claim to the Agency without a copy of the Medicare EOB attached.
  - ✓ The claim format billed to Medicare does not match the claim format billed to Medical Assistance.
  - ✓ The coding and dollar amount billed do not match (paper claims).
  - ✓ Failure to fill data in all required fields on the DDE crossover screen.

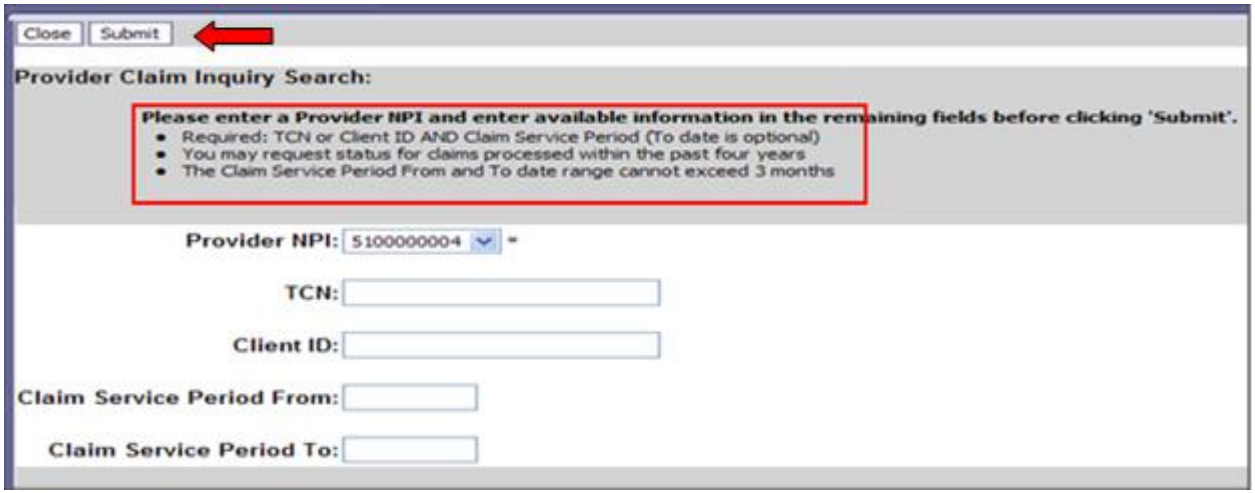
Life of a Claim



Claim Inquiry

Claim Inquiry

- How do I find claims in ProviderOne?
  - ✓ Choose the **"Claim Inquiry"** Option from the Provider Portal
  - ✓ Enter search data then click on the **"Submit"** button.



Washington State Health Care Authority

Claim Inquiry

- Claim Transaction Control Number (TCN's) returned
  - ✓ Click on the **"TCN"** number to view the claim data.
  - ✓ Denied claims will show the denial codes.
  - ✓ Easiest way to find a timely TCN number for re-bills.

Claim Inquiry Providers List:

	TCN	Date of Service	Claim Status	Claim Charged Amount
☐	1030200005720000	10/14/2010	0: Cannot provide further status electronically.	$888.00
☐	1101100018152000	10/14/2010	0: Cannot provide further status electronically.	$888.00
☐	1105400007698000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1106100031712000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1106600001668000	10/14/2010	1: For more detailed information, see remittance advice.	$750.00
☐	1106600003011000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1107500035007000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1108200019887000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1113600005638000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1114400017409000	10/14/2010	1: For more detailed information, see remittance advice.	$750.00

<< Prev | Viewing Page 1 | Next >> | 2 | Go | Page Count = 2 | SaveToXLS

Why can't I pull up my claim?!

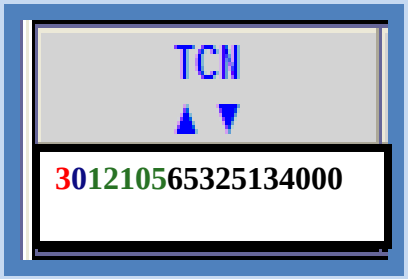
- There are many reasons why you might not be able to retrieve a claim (for any system functions).
  - ✓ It has been Adjusted, you can't retrieve a claim that has already been Adjusted.
  - ✓ It has been replaced by another claim.
  - ✓ It hasn't finished processing.
  - ✓ It was billed under a different domain.
  - ✓ You could be using the wrong profile.
  - ✓ You submitted by batch with more than 1 NDC on a claim line.
  - ✓ Trying to do a Resubmit on a paid claim or an Adjustment to a denied claim.
  - ✓ Claims billed with an NPI not reported in ProviderOne.
  - ✓ Claims billed with an ID only rendering provider NPI number as the pay-to provider.

Billing Timely

- What are the Agency's timeliness guidelines?
  - ✓ The initial billing must occur within 365 days from the date of service on the claim.
  - ✓ Providers are allowed 2 years in total to get a claim paid or adjusted.
  - ✓ For Delayed Certification client eligibility the Agency allows 12 months from the Delayed Cert date to bill.
  - ✓ Recoupment's from other payers-timeliness starts from the date of the recoupment, not the date of service.
  - ✓ Trimester care-determined from the Expected Date of Delivery (EDD), EDD must be noted on the claim.
  - ✓ The Agency uses the Julian calendar for dates.
  - ✓ Crossover and Pharmacy claims have different timeliness guidelines.

What is a TCN?

TCN=Transaction Control Number



18 digit number that ProviderOne assigns to each claim received for processing. TCN numbers are never repeated.

How do I read a TCN?

1st digit-Claim Medium Indicator	2nd digit-Type of claim	3rd thru 7th digits-date claim was received
• 1-paper • 2-Direct Data Entry • 3-electronic, batch submission • 4-system generated (Credits/Adjustment)	• 0-Medical • 2-Crossover or Medical	• 3rd and 4th digits are the year • 5th, 6th and 7th digits are the day it was received

Example TCN:30121046532513400 0

3-electronic submission via batch

0-medical claim

12-year claim was received, 2012

104-day claim was received, April 13th

How do I prove timeliness?

- HIPAA batch transaction
  - ✓ Electronic submission-Professional, Institutional & Dental
    - Enter the timely TCN in the claim note, Loop 2300, segment NTE02=TCN*

*837I institutional has 2 NTE segments, we capture information from either segment.

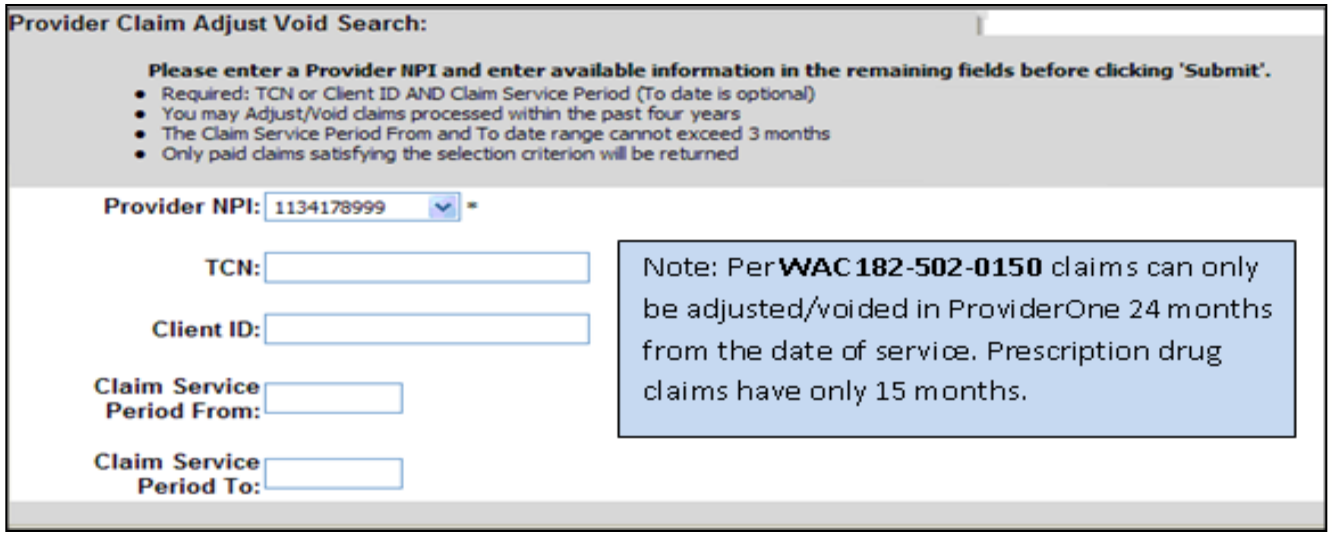
- Direct Data Entry (DDE) Claims
  - ✓Resubmit Original Denied/Voided Claim; or
  - ✓Enter timely TCN in the "Claim Note"
  - ✓Enter recoupment statement in "Claim Note"
    "Recouped for SSI, 00/00/00"
  - ✓Enter EDD date in "Claim Note"

How do I prove timeliness?

- Paper billing-CMS-1500
  - ✓ Enter timely TCN in box 22
  - ✓ Enter the recoupment date in box 19
  - ✓ Enter the EDD date in box 19
- Paper billing-UB04
  - ✓ Enter timely TCN in box 64 a-c
- Paper billing-ADA
  - ✓ Enter timely TCN in box 35

Adjust/Void a Paid Claim

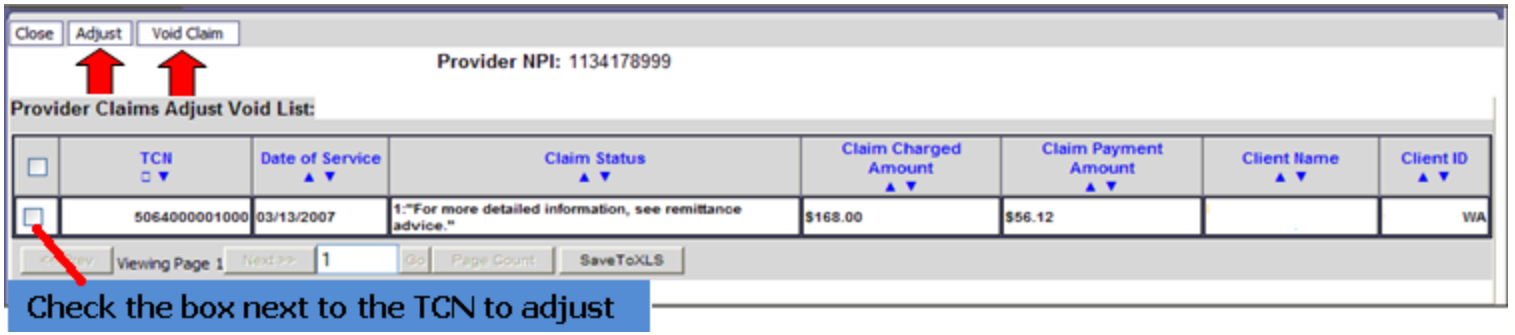
- Select "Claim Adjustment/Void" from the Provider Portal.



- Enter the TCN number if known; or
- Enter the Client ID, and the From-To date of service.

Adjust/Void a Paid Claim

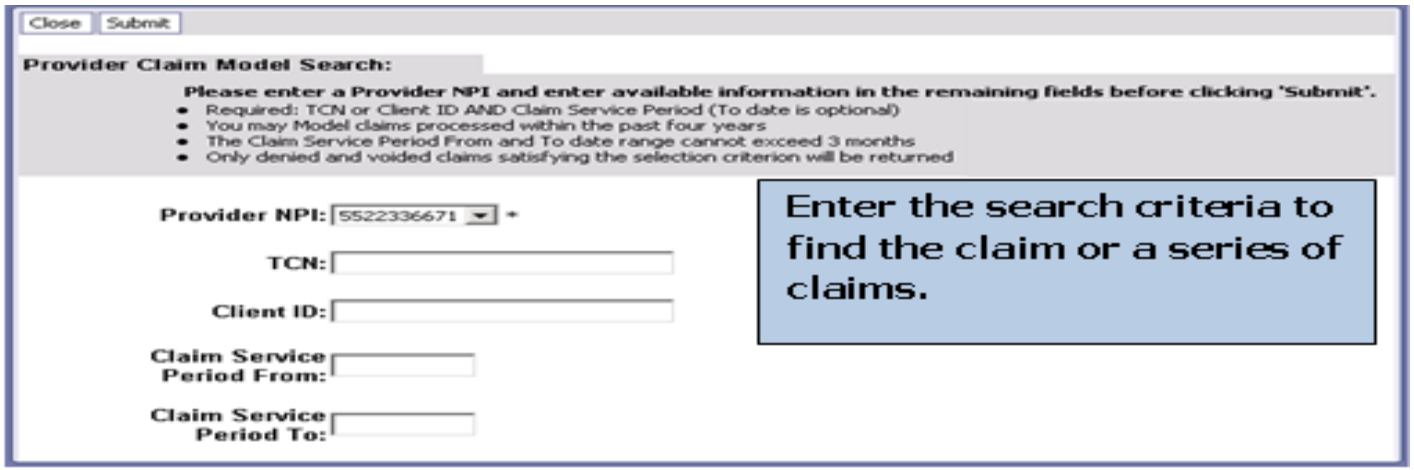
- The system will display the paid claim(s) based on the search criteria.



- Check the box of the TCN to adjust/void.
- ProviderOne loads the DDE screen with the claim data.
  - ✓ Update the claim information to adjust, then submit.
  - ✓ Claim data can not be changed when doing a void, just submit the void.

Resubmit a Denied Claim

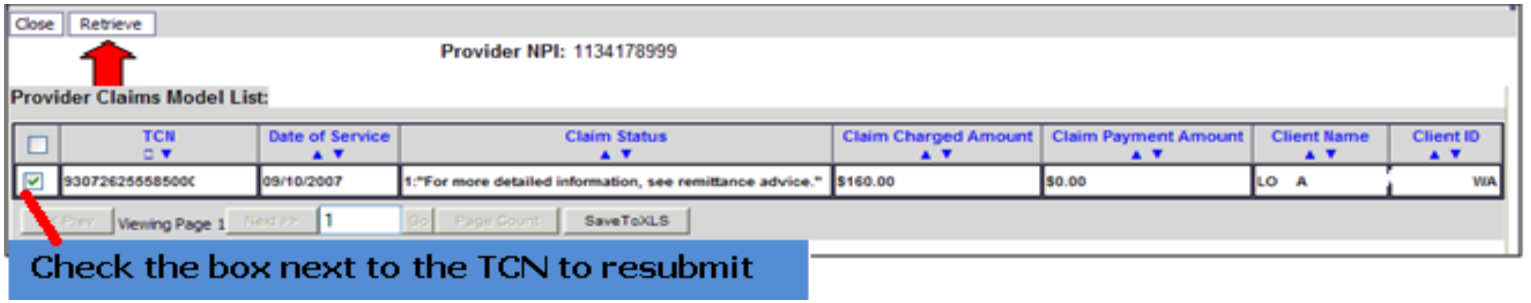
- Select "Resubmit Denied/Voided Claim" from the Provide Portal.



- A TCN will bring up only one claim.
- Enter the Client ID and the From-To dates of service to find all claims billed these dates.

Resubmit a Denied Claim

- The system will display the claim(s) based on the search criteria.

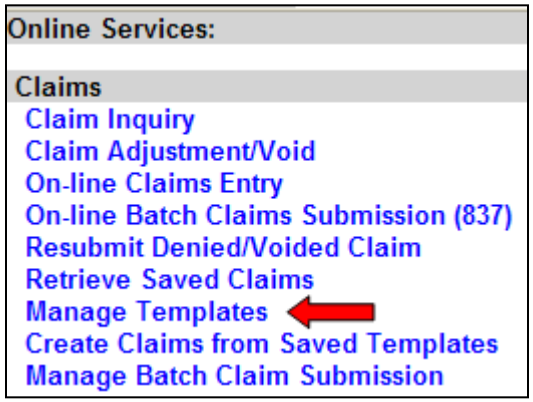


- Check the box of the TCN to resubmit.
- ProviderOne loads the DDE screen with the claim data.
  - ✓ Update the claim information that caused the claim to deny, then submit.

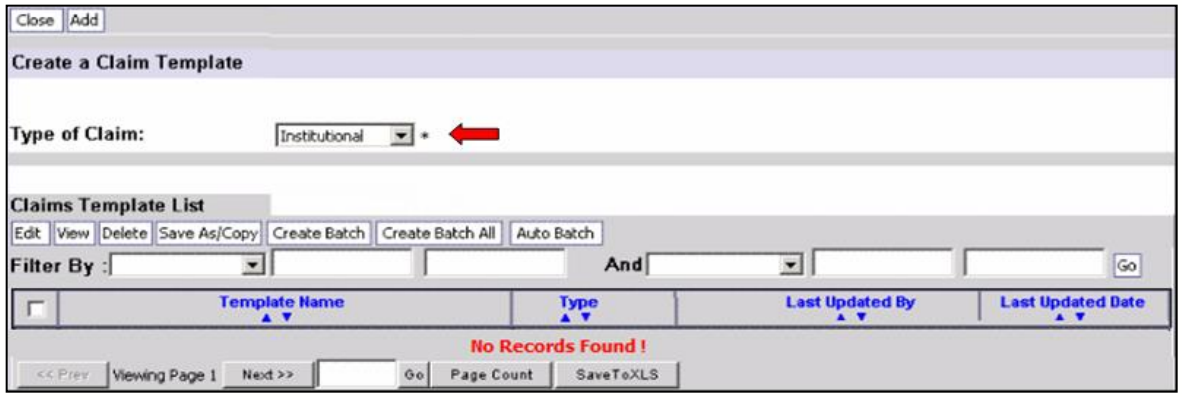
Creating a Claim Template

- ProviderOne allows creating and saving templates.

  ✓ Log into ProviderOne.
  ✓ Click on the **"Manage Templates"** hyperlink.



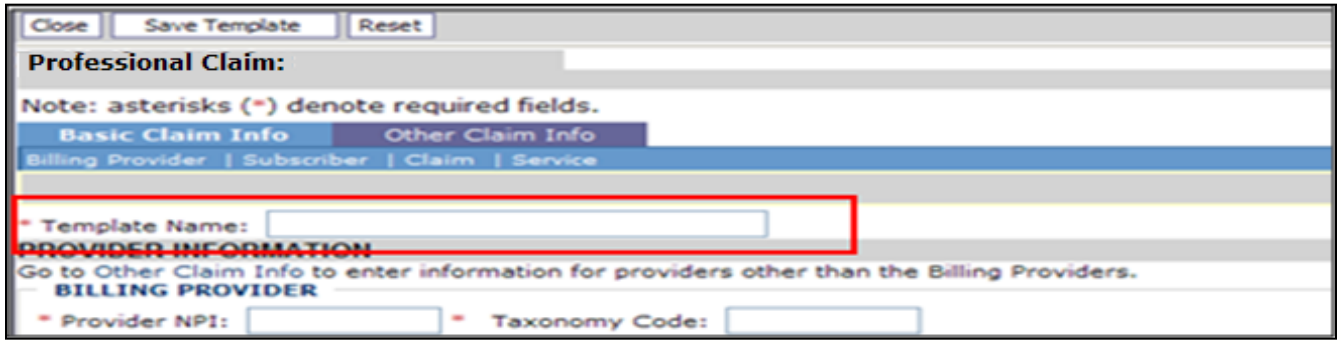
  ✓ At the Create a Claim Template and list screen, click the **"Type of Claim"** Option.



Washington State Health Care Authority

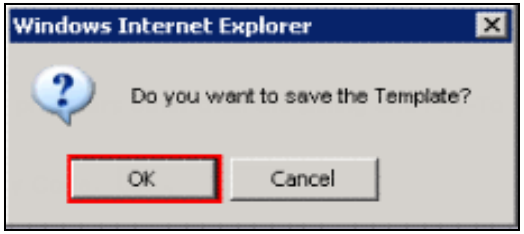
Creating a Claim Template

- Once a template type is picked the system opens in the DDE screen.



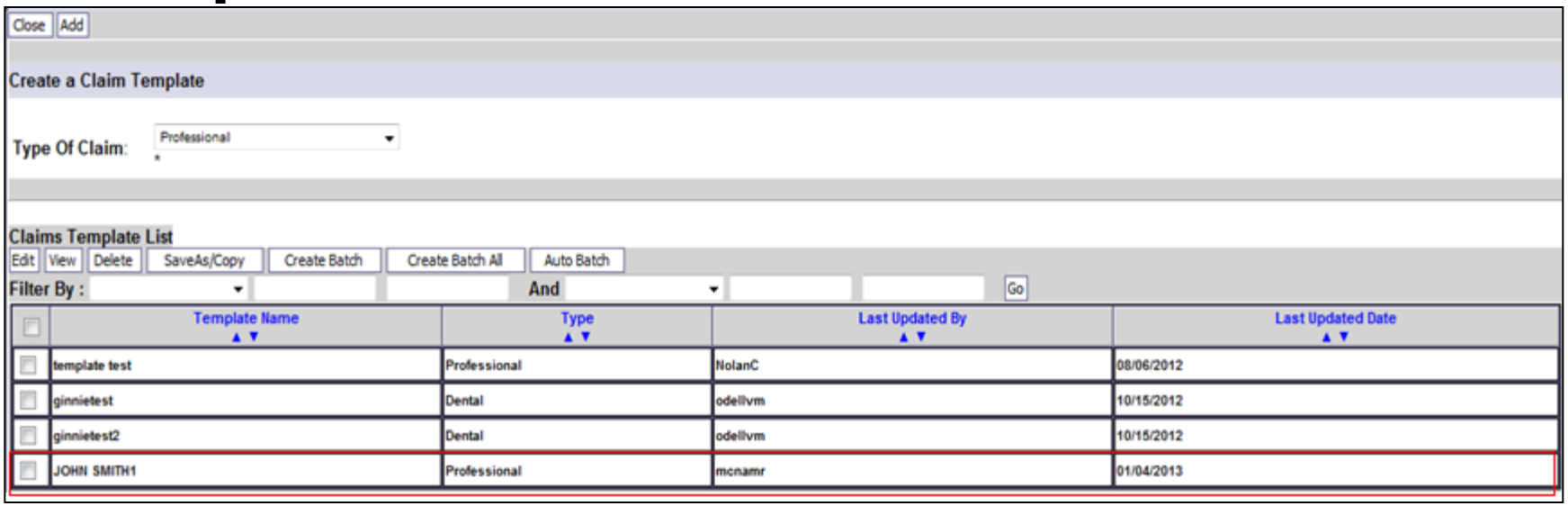
- Name the template then fill in as much data as wanted on the template.

- Click on the **"Save Template"** button and the system verifies you are saving the template. Click on the **"OK"** button to save template.



Creating a Claim Template

- After the template is saved it is listed on the **"Claim Template List"**.

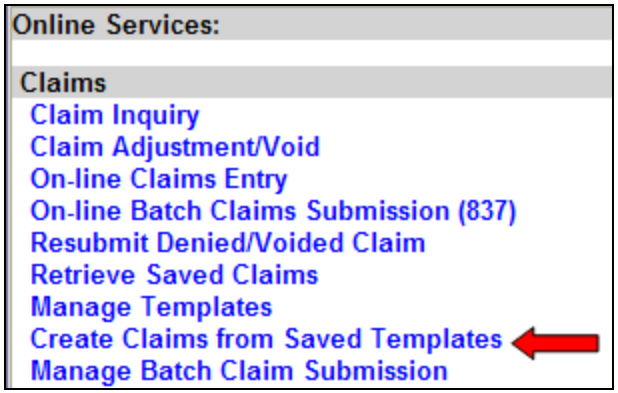


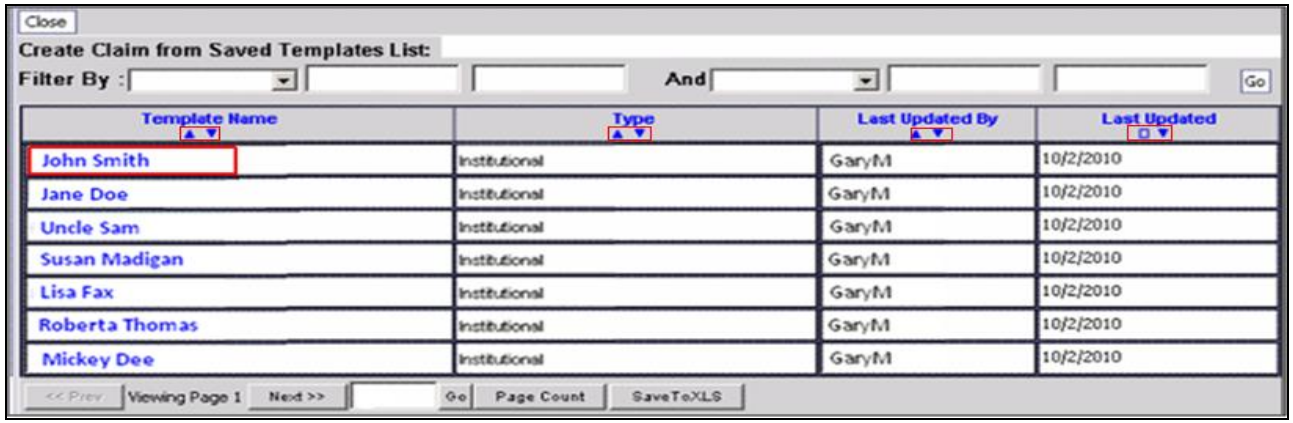
- Additional templates can be created:
  - ✓ Copying a template on the list; or
  - ✓ Creating another from scratch.
- Templates can be edited, viewed, and deleted.

Submitting a Template Claim

- Claims can be submitted from a Template.

✓ Log into ProviderOne.
✓ Click on the **"Create Claims from Saved Templates"** hyperlink.
✓ At the Saved Template List find the template to use. (sort the list using the sort tools outlined)

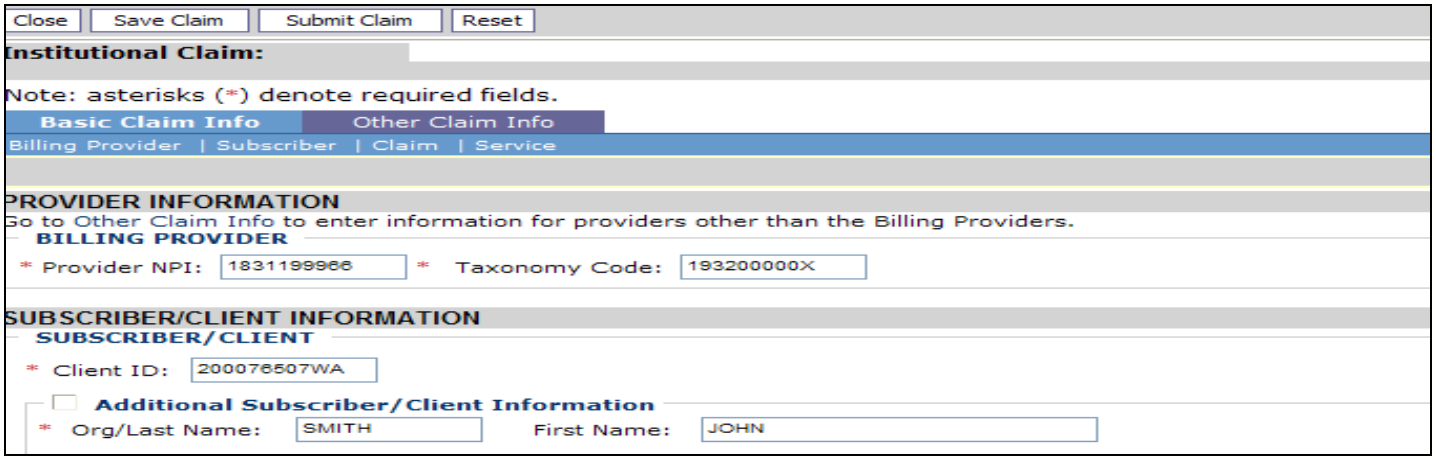




Washington State Health Care Authority

Submitting a Template Claim

- Click on the Template name.
- The DDE screen is loaded with the template.



- Enter or update the data for claim submission then submit the claim.
- Batches of Template Claims can be created.
- See the Batch Template webinar at http://www.hca.wa.gov/medicaid/provider/Pages/webinar.aspx

Reading the Remittance Advice (RA)

Reading the Remittance Advice (RA)

- How do I retrieve the PDF file for the RA?
  - ✓ Log into ProviderOne with a **Claims/Payment Status Checker, Claims Submitter, or Super User** profile.

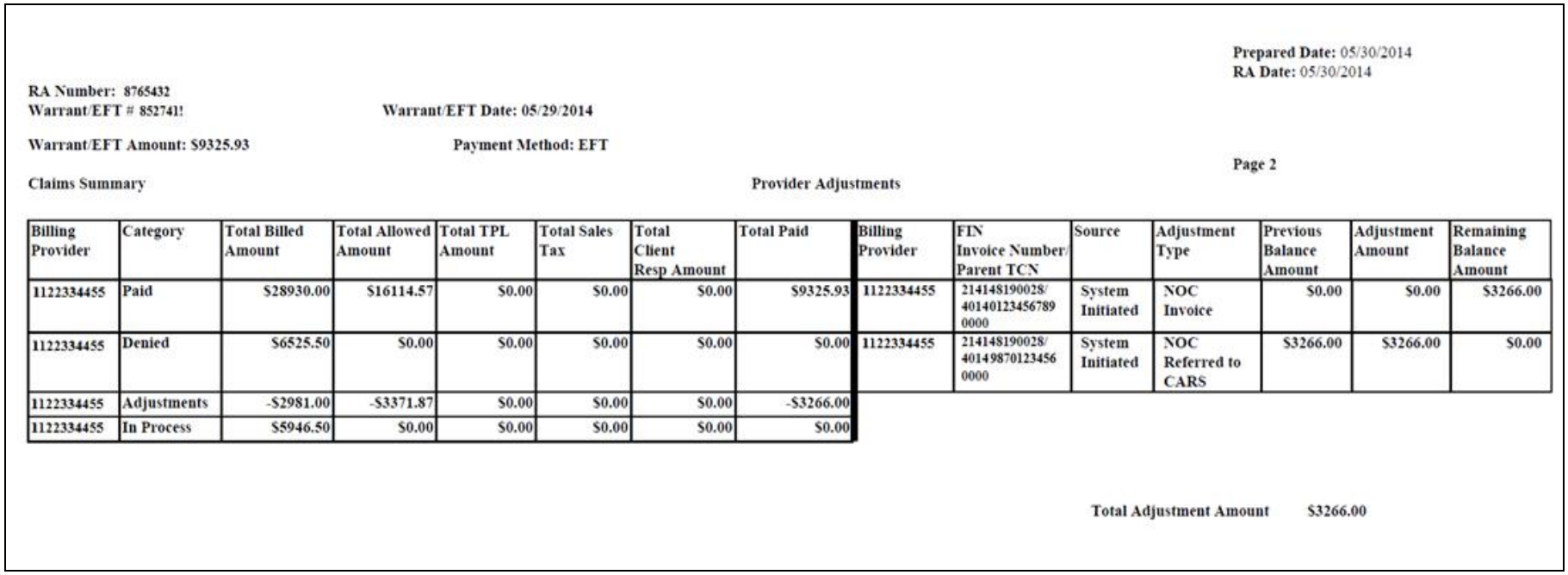
  - ✓ At the Portal click on the hyperlink **View Payment**.
  - ✓ The system should open your list of RAs.

RA/ETRR Number	Check Number	Check/ETRR Date	RA Date	Claim Count	Charges	Payment Amount	Adjusted Amount	Download
2444447	000777	02/23/2012	02/24/2012	1428	$513,899.73	$62,865.54	$408,607.26	
2443392	000778	02/16/2012	02/17/2012	1538	$484,679.55	$63,959.26	$375,030.04	
2229984	004772	02/09/2012	02/10/2012	1384	$488,482.16	$80,452.68	$408,029.48	

  - ✓ Click on the **RA number** in the first column to open the whole RA.

Reading the Remittance Advice (RA)

- The Summary Page of the RA shows:
  - ✓ Billed and paid amount for Paid claims
  - ✓ Billed amount of denied claims
  - ✓ Total amount of adjusted claims
  - ✓ Provider adjustment activity



Prepared Date: 05/30/2014
RA Date: 05/30/2014

RA Number: 8765432
Warrant/EFT # 852741!
Warrant/EFT Date: 05/29/2014

Warrant/EFT Amount: $9325.93
Payment Method: EFT

Page 2

Claims Summary

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total TPL Amount	Total Sales Tax	Total Client Resp Amount	Total Paid
1122334455	Paid	$28930.00	$16114.57	$0.00	$0.00	$0.00	$9325.93
1122334455	Denied	$6525.50	$0.00	$0.00	$0.00	$0.00	$0.00
1122334455	Adjustments	-$2981.00	-$3371.87	$0.00	$0.00	$0.00	-$3266.00
1122334455	In Process	$5946.50	$0.00	$0.00	$0.00	$0.00	$0.00

Provider Adjustments

Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
1122334455	214148190028/ 40140123456789 0000	System Initiated	NOC Invoice	$0.00	$0.00	$3266.00
1122334455	214148190028/ 40149870123456 0000	System Initiated	NOC Referred to CARS	$3266.00	$3266.00	$0.00

Total Adjustment Amount $3266.00

Reading the Remittance Advice (RA)

- Provider Adjustments:
  - ✓ These adjustment amounts can carry over on each week's RA until the amount is paid off or reduced by the amount paid out for claims adjudicated that week.
  - ✓ Claims that caused these carry over adjustment amounts can be on previous RAs.
  - ✓ A recent update to the RA format now populates the parent TCN under the FIN Invoice Number for reference.
  - ✓ Credit balance RAs have a "check number" that looks like this: **JVAH0223344556677800**.
  - ✓ ProviderOne automatically sends the credit balance amounts to our finance office after 180 days if the NPI number does not generate claim payments.

Reading the Remittance Advice (RA)

RA Number: 8765432 Warrant/EFT #: 852741! Warrant/EFT Date: 06/05/2014 Prepared Date: 06/06/2014 RA Date: 06/06/2014

Category: Denied Billing Provider: 1122334455 Page 15

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
SMITH, JOHN D 147258369WA 100694KR 98164	201498798798798798 Dental Claim	1		05/07/2014- 05/07/2014	D0210	1.0000	$44.53	$0.00	$0.00	$0.00	$0.00	$0.00		119 = $44.53
			Document Total:	05/07/2014-05/07/2014		1.0000	$44.53	$0.00	$0.00	$0.00	$0.00	$0.00		
SMITH, JOHN D 147258369WA 100329KS 91353	201496385274196385 Dental Claim	1		05/09/2014- 05/09/2014	D5212	1.0000	$276.28	$0.00	$0.00	$0.00	$0.00	$0.00		15 = $276.28
			Document Total:	05/09/2014-05/09/2014		1.0000	$276.28	$0.00	$0.00	$0.00	$0.00	$0.00		15
SMITH, JOHN D 147258369WA 100672AT 100453	201445612378945612 Dental Claim	1		05/06/2014- 05/06/2014	D9230	1.0000	$20.00	$0.00	$0.00	$0.00	$0.00	$0.00		119 = $20.00
			Document Total:	05/06/2014-05/06/2014		1.0000	$20.00	$0.00	$0.00	$0.00	$0.00	$0.00		
				Category Total:		16.0000	$904.81	$0.00	$0.00	$0.00	$0.00	$0.00		

Reading the Remittance Advice (RA)

- EOB Codes
  - ✓ The Adjustment Reason Codes; and
  - ✓ The Remark Codes for denied claims & payment adjustments are located on the last page of the RA.

Adjustment Reason Codes / NCPDP Rejection Codes
119 : Benefit maximum for this time period or occurrence has been reached. 15 : The authorization number is missing, invalid, or does not apply to the billed services or provider. 16 : Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. 18 : Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) 35 : Lifetime benefit maximum has been reached. 96 : Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Remark Codes
N20 : Service not payable with other service rendered on the same date. N329 : Missing/incomplete/invalid patient birth date. N37 : Missing/incomplete/invalid tooth number/letter. N39 : Procedure code is not compatible with tooth number/letter.

  - ✓ The complete list of Federal codes can be located on **http://www.wpc-edi.com/reference/**

Authorization

Authorization

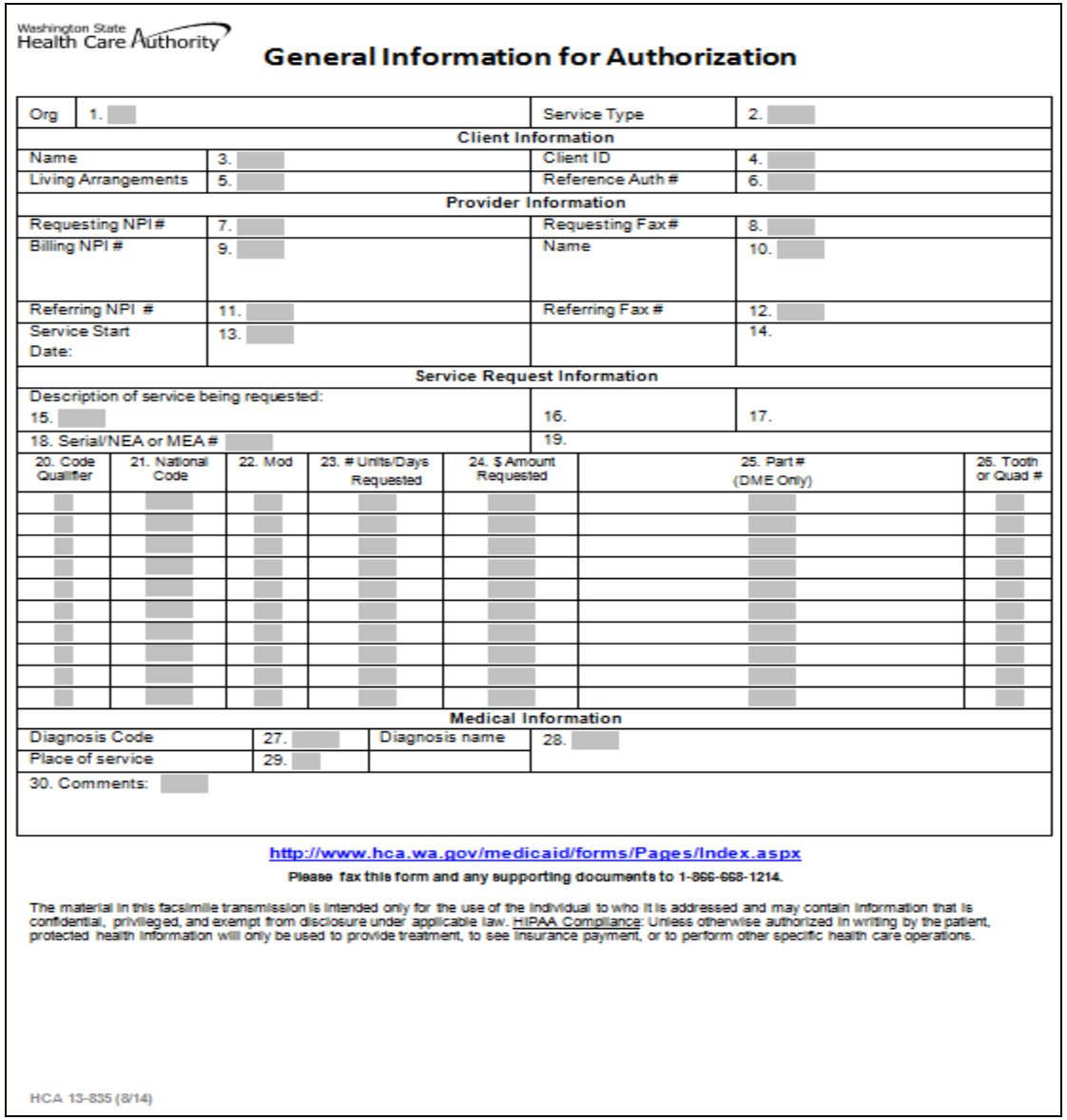
1. Complete Authorization Form 13-835
2. Submit Authorization Request to the Agency with Required Back-up
3. Check the Status of a Request
4. Send in Additional Documentation if Requested by the Agency

Authorization

- Complete Authorization Form **13-835**
  a) To begin the authorization process providers need to complete HCA Form 13-835. ProviderOne can begin processing the authorization request once the Agency receives this form filled out correctly.
  b) Access the online authorization form 13-835 at http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx

Step by step instructions:

ProviderOne Billing and Resource Guide



Washington State Health Care Authority

General Information for Authorization

Org	1.	Service Type	2.
Client Information			
Name	3.	Client ID	4.
Living Arrangements	5.	Reference Auth #	6.
Provider Information			
Requesting NPI #	7.	Requesting Fax #	8.
Billing NPI #	9.	Name	10.
Referring NPI #	11.	Referring Fax #	12.
Service Start Date:	13.		14.
Service Request Information			
Description of service being requested: 15.		16.	17.
18. Serial/NEA or MEA #		19.	

20. Code Qualifier	21. National Code	22. Mod	23. # Units/Days Requested	24. $ Amount Requested	25. Part # (DME Only)	26. Tooth or Quad #

Medical Information			
Diagnosis Code	27.	Diagnosis name	28.
Place of service	29.		
30. Comments:			

http://www.hca.wa.gov/medicaid/forms/Pages/Index.aspx

Please fax this form and any supporting documents to 1-866-668-1214.

The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. HIPAA Compliance: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to see insurance payment, or to perform other specific health care operations.

HCA 13-835 (8/14)

Directions for Authorization form 13-835

Instructions to fill out the General Information for Authorization form, HCA 13-835

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
1	Org **(Required)**	Enter the Number that Matches the Program/Unit for the Request 501 – Dental 502 – Durable Medical Equipment (DME) 504 – Home Health 505 – Hospice 506 – Inpatient Hospital 508 – Medical 509 – Medical Nutrition 511 – Outpt Proc/Diag 513 – Physical Medicine & Rehabilitation (PM & R) 514 – Aging and Long-Term Support Administration (ALTSA) 518 – LTAC 519 – Respiratory 521 – Maternity Support/Infant Case Management 524 – Concurrent Care 525 – ABA Services 526 – Complex Rehabilitation Technology (CRT) 527 – Chemical-Using Pregnant (CUP) Women Program
2	Service Type **(Required)**	Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected "501 – **Dental**" for field #1, please select one of the following codes for this field: ASC for ASC CWN for Crowns DEN for Dentures DP for Denture/Partial ERSO for ERSO-PA EXT for Extractions EXTD for Extractions w/Dentures IP for In-Patient ODC for Orthodontic OUTP for Out-Patient PSM for Perio-Scaling/Maintenance PTL for Partial RBS for Rebases RLNS for Relines MISC for Miscellaneous If you selected "502 – **Durable Medical Equipment (DME)**" for field #1, please select one of the following codes for this field: AA for Ambulatory Aids BB for Bath Bench BEM for Bath Equipment (misc.) BGS for Bone Growth Stimulator BP for Breast Pump C for Commode CG for Compression Garments CSC for Commode/Shower Chair DTS for Diabetic Testing Supplies (See Pharmacy Billing Instructions for POS Billing) ERSO for ERSO-PA FSFS for Floor Sitter/Feeder Seat HB for Hospital Beds HC for Hospital Cribs IS for Incontinent Supplies MWH for Manual Wheelchair - Home MWNF for Manual Wheelchair – NF MWR for Manual Wheelchair Repair OS for Orthopedic Shoes OTC for Orthotics OP for Ostomy Products ODME for Other DME OTRR for Other Repairs PL for Patient Lifts PWH for Power Wheelchair - Home PWNF for Power Wheelchair – NF PWR for Power Wheelchair Repair PRS for Prone Standers PROS for Prosthetics RE for Room Equipment SC for Shower Chairs SBS for Specialty "Beds/Surfaces SGD for Speech Generating Devices SF for Standing Frames STND for Standers TU for TENS Units US for Urinary Supplies WDCS for VAC/Wound - decubiti supplies MISC for Miscellaneous

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
2	Service Type **(Required)** (Continued)	If you selected "504 – **Home Health**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA HH for Home Health MISC for Miscellaneous I for Therapies (PT / OT / ST) If you selected "505 – **Hospice**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA HSPC for Hospice MISC for Miscellaneous If you selected "506 – **Inpatient Hospital**" for field #1, please select one of the following codes for this field: BS for Bariatric Surgery ERSO for ERSO-PA OOS for Out of State O for Other PAS for PAS RM for Readmission S for Surgery TNP for Transplants VNSS for Vagus Nerve Stimulator MISC for Miscellaneous If you selected "508 – **Medical**" for field #1, please select one of the following codes for this field: BSS2 for Bariatric Surgery Stage 2 BTX for Botox CIERP for Cochlear Implant Exterior Replacement Parts CR for Cardiac Rehab ERSO for ERSO-PA HEA for Hearing Aids I for Infusion / Parental Therapy MC for Medications NP for Neuro-Psych OOS for Out of State PSY for Psychotherapy SYN for Synagis T for Therapies (PT/OT/ST) TX for Transportation V for Vision VST for Vest VT for Vision Therapy MISC for Miscellaneous If you selected "509 – **Medical Nutrition**" for field #1, please select one of the following codes for this field: EN for Enteral Nutrition MN for Medical Nutrition MISC for Miscellaneous If you selected "511 – **Output Proc/Diag**" for field #1, please select one of the following codes for this field: CCTA for Coronary CT Angiogram CI for Cochlear Implants ERSO for ERSO-PA GCK for Gamma/Cyber Knife GT for Genetic Testing HO for Hyperbaric Oxygen HY for Hysterectomy MRI for MRI OOS for Out of State OTRS for Other Surgery PSCN for PET Scan O for Other S for Surgery SCAN for Radiology MISC for Miscellaneous If you selected "513 – **Physical Medicine & Rehabilitation (PM & R)**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA PMR for PM and R MISC for Miscellaneous

Directions for Authorization form 13-835

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
2	Service Type **(Required)** (Continued)	If you selected "514 – **Aging and Long-Term Support Administration (ALTSA)** for field #1, please select one of the following codes for this field: PDN for Private Duty Nursing MISC for Miscellaneous
		If you selected "518 – **LTAC**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA LTAC for LTAC O for Other
		If you selected "519 – **Respiratory**" for field #1, please select one of the following codes for this field: CPAP for CPAP/BiPAP ERSO for ERSO-PA NEB for Nebulizer OXM for Oximeter OXY for Oxygen SUP for Supplies VENT for Vent O for Other
		If you selected "521 – **Maternity Support/Infant Case Management (MSS)**" for field #1, please select one of the following codes for this field: ICM for Infant Case Management PO for Post Pregnancy Only PPP for Prenatal/Post Pregnancy O for Other
		If you selected "524 – **Concurrent Care**" (for children on Hospice) for field #1, please select one of the following codes for this field: CC for Concurrent Care Services
		Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected "525 – **ABA Services**" for field #1, please select one of the following codes for this field: IH for In Home/Community/Office DAYP for Day Program
		If you selected "526 – **Complex Rehabilitation Technology**" (CRT) for field #1, please select one of the following codes for this field: ERSO for ERSO-PA MWH for Manual Wheelchair - Home MWNF for Manual Wheelchair - NF MWR for Manual Wheelchair Repairs MWS for Manual Wheelchair Supplies PWH for Power Wheelchair - Home PWNF for Power Wheelchair – NF PWR for Power Wheelchair Repairs PWS for Power Wheelchair Supplies
		If you selected "527 – **Chemical-Using Pregnant (CUP) Women Program**" for field #1, please select one of the following codes for this field: DX for Detox DM for Detox/Medical Stabilization MS for Medical Stabilization

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
3	Name: **(Required)**	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: **(Required)**	Enter the client ID - 9 numbers followed by WA. For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): ▪ You will need to contact HCA at 1-800-562-3022 and the appropriate extension of the Authorization Unit. ▪ A reference PA will be built with a placeholder client ID. ▪ If the PA is approved – once the client ID is known – you will need to contact HCA either by fax or phone with the Client ID. The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: **(Required)**	The 10 digit number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Billing NPI #: **(Required)**	The 10 digit number that has been assigned to the billing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: **(Required).**	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA or MEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA/MEA# to access the x-rays/pictures for this request.
20	Code Qualifier: **(Required).**	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S – ICD-9/10 Diagnosis Code
21	National Code: **(Required).**	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: **(Units or $ required).**	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific Medicaid Provider Guide for the appropriate unit/day designation for the service code entered).
24	$ Amount Requested: **(Units or $ required).**	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Medicaid Provider Guide and fee schedules for assistance) Must be entered in dollars & cents with a decimal (e.g. $400 should be entered as 400.00).
25	Part # (DME only): **(Required for all requested codes).**	Enter the manufacturer part # of the item requested.

Directions for Authorization form 13-835

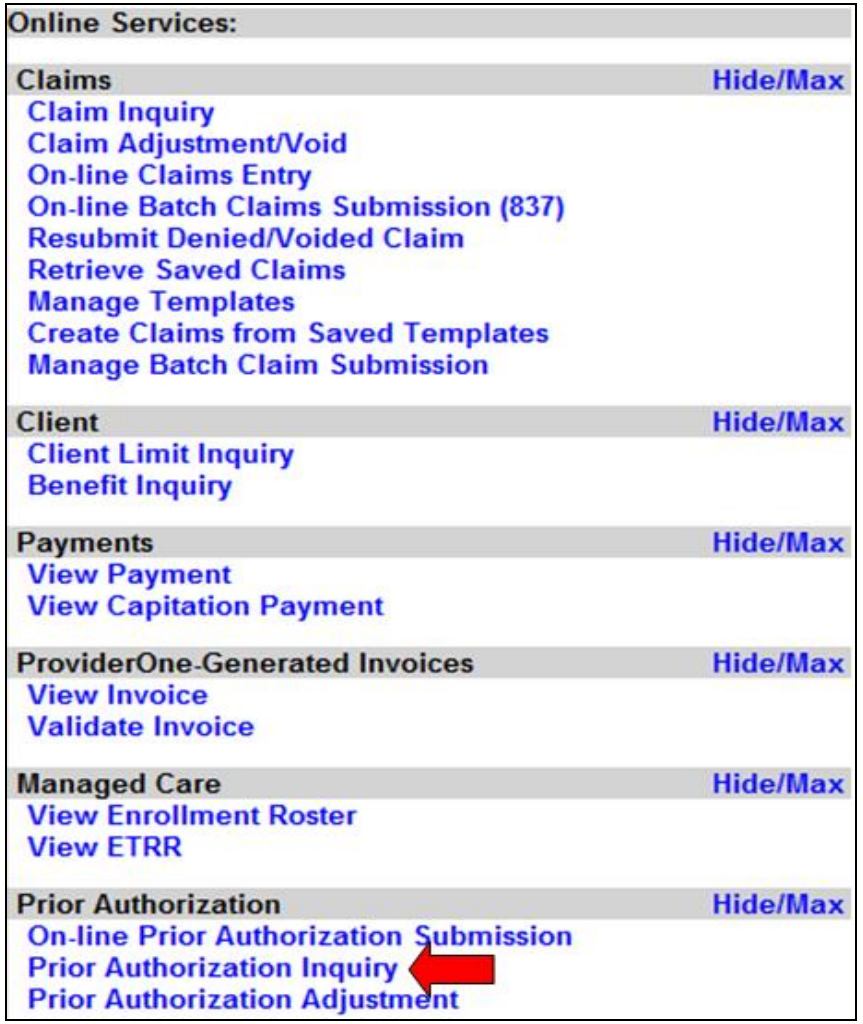
FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
26	Tooth or Quad#: (Required for dental requests).	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-32, A-T, AS-TS, and 51-82
27	Diagnosis Code	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code.

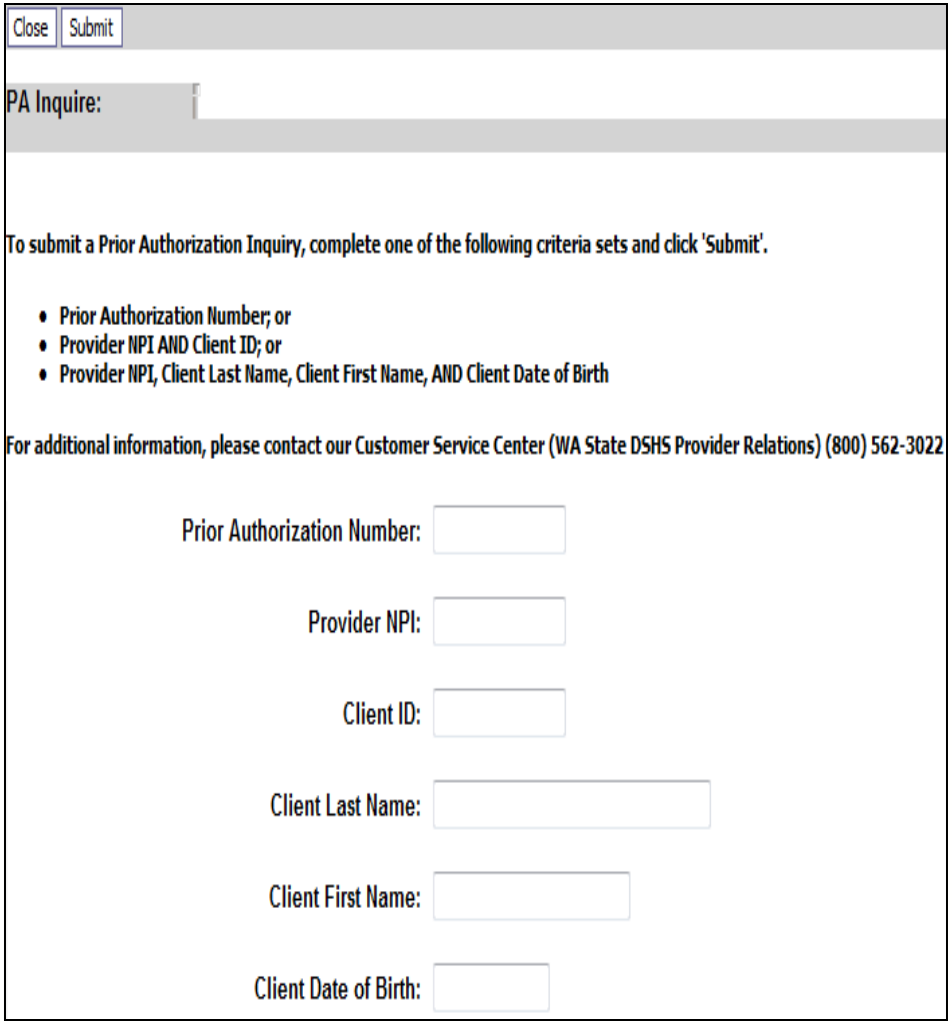
Place of Service Code(s)

1	Place of Service Name
3	Pharmacy
4	School
5	Homeless Shelter
6	Indian Health Service Free-standing Facility
7	Indian Health Service Provider-based Facility
8	Tribal 638 Free-standing Facility
9	Tribal 638 Provider-based Facility
11	Prison-Correctional Facility
12	Office
13	Home
14	Assisted Living Facility
15	Group Home
16	Mobile Unit
17	Temporary Lodging
20	Walk in Retail Health Clinic
21	Urgent Care Facility
22	Inpatient Hospital
23	Outpatient Hospital
24	Emergency Room – Hospital
25	Ambulatory Surgical Center
26	Birthing Center
31	Military Treatment Facility
32	Skilled Nursing Facility
33	Nursing Facility
34	Custodial Care Facility
41	Hospice
42	Ambulance - Land
49	Ambulance – Air or Water
50	Independent Clinic
51	Federally Qualified Health Center
52	Inpatient Psychiatric Facility

FIELD	NAME	ACTION	
		ALL FIELDS MUST BE TYPED.	
29	Place of Service	53	Psychiatric Facility-Partial Hospitalization
		55	Community Mental Health Center
		56	Residential Substance Abuse Treatment Facility
		57	Psychiatric Residential Treatment Center
		60	Non-residential Substance Abuse Treatment Facility
		61	Mass Immunization Center
		62	Comprehensive Inpatient Rehabilitation Facility
		65	Comprehensive Outpatient Rehabilitation Facility
		71	End-Stage Renal Disease Treatment Facility
		72	Public Health Clinic
		81	Rural Health Clinic
		99	Independent Laboratory
30	Comments	Enter any free form information you deem necessary.	Other Place of Service

Check Status of an Authorization Request

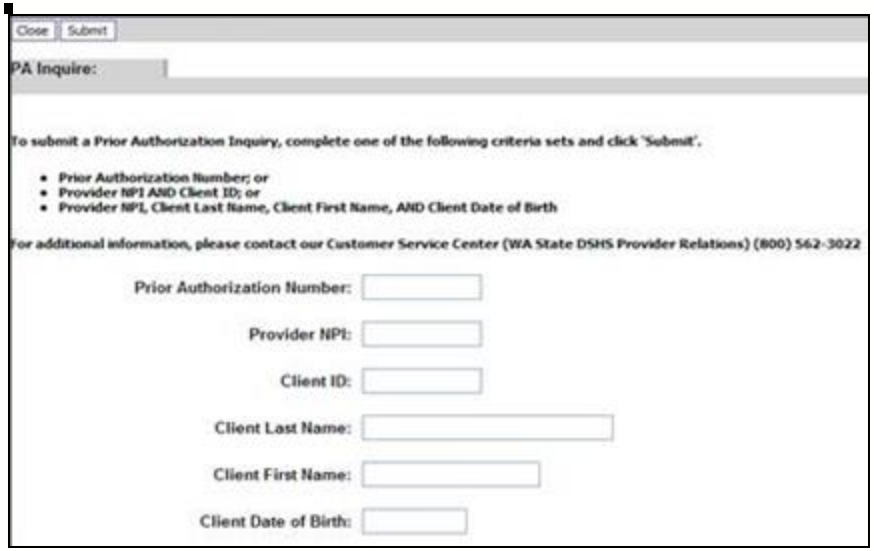




Washington State Health Care Authority

Check Status of an Authorization Request

- Select **Provider Authorization Inquiry** from the provider home page.
  - ✓ Search by one of the Options:
    - Prior Authorization number; or
    - Provider NPI and Client ID; or
    - Provider NPI, Client Last & First Name, and the client birth date.
  - ✓ The system may return the following status information:



PA Utilization:

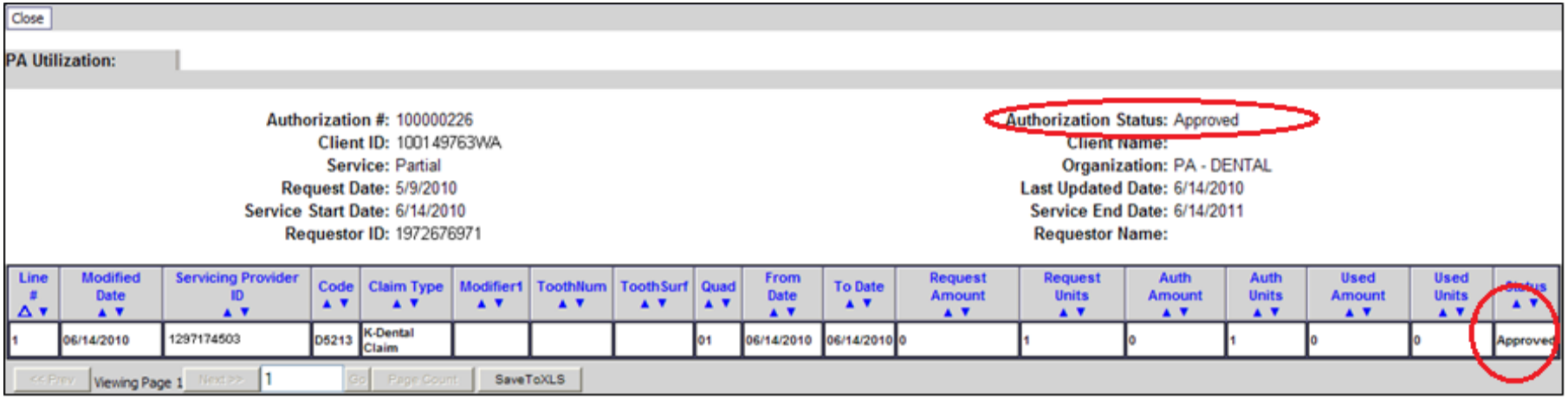
Authorization #: 870000004
Client ID: 9999999WA
Service: Miscellaneous
Request Date: 12/23/2010
Service Start Date: 1/1/2011
Requestor ID: 8888888897

Authorization Status: Approved
Client Name:
Organization: PA - DENTAL
Last Updated Date: 8/17/2011
Service End Date: 9/30/2011
Requestor Name: Place Holder PA Provider

Line #	Modified Date	Servicing Provider ID	Code	Claim Type	Modifier1	ToothNum	ToothSurf	Quad	From Date	To Date	Request Amount	Request Units	Auth Amount	Auth Units	Used Amount	Used Units	Status
1	08/17/2011	8888888897	D0120	K-Dental Claim					01/01/2011	09/30/2011	0	99999	0	1	0	0	Approved

Washington State Health Care Authority

Check the Status of a Request


Close

PA Utilization:

Authorization #: 100000226
Client ID: 100149763WA
Service: Partial
Request Date: 5/9/2010
Service Start Date: 6/14/2010
Requestor ID: 1972676971

Authorization Status: Approved
Client Name:
Organization: PA - DENTAL
Last Updated Date: 6/14/2010
Service End Date: 6/14/2011
Requestor Name:

Line #	Modified Date	Servicing Provider ID	Code	Claim Type	Modifier1	ToothNum	ToothSurf	Quad	From Date	To Date	Request Amount	Request Units	Auth Amount	Auth Units	Used Amount	Used Units	Status
1	06/14/2010	1297174503	D5213	K-Dental Claim				01	06/14/2010	06/14/2010	0	1	0	1	0	0	Approved

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

Requested	This means the authorization has been requested and received.
In Review	This means your authorization is currently being reviewed.
Cancelled	This means the authorization request has been cancelled.
Pended	This means we have requested additional information in order to make a decision on the request.
Referred	This means the request has been forwarded to a second level reviewer.
Approved/Hold	This means the request has been approved, but additional information is necessary before the authorization will be released for billing.
Approved/Denied	This means the request has been partially approved and some services have been denied.
Rejected	This means the request was returned to you as incomplete.
Approved	This means the Department has approved your request.
Denied	This means the Department has denied your request.

The above example authorization request (number) is in approved status. Other possible status of the authorization request is listed in the table at the left.

Submit Prior Authorization Request

ProviderOne

PA Pend Forms Submission Cover Sheet

Authorization Reference # 123456789

(Please enter 9 digit numeric value.)

Print Cover Sheet Clear Fields

Instructions will not appear on the printed coversheet

INSTRUCTIONS:
Click ENTER on your keyboard after typing the number in above.

Please use the **Print Cover Sheet** Button Above to print ONLY.

Use Only ADOBE Reader to generate this coversheet. Other readers will not generate the barcode correctly.

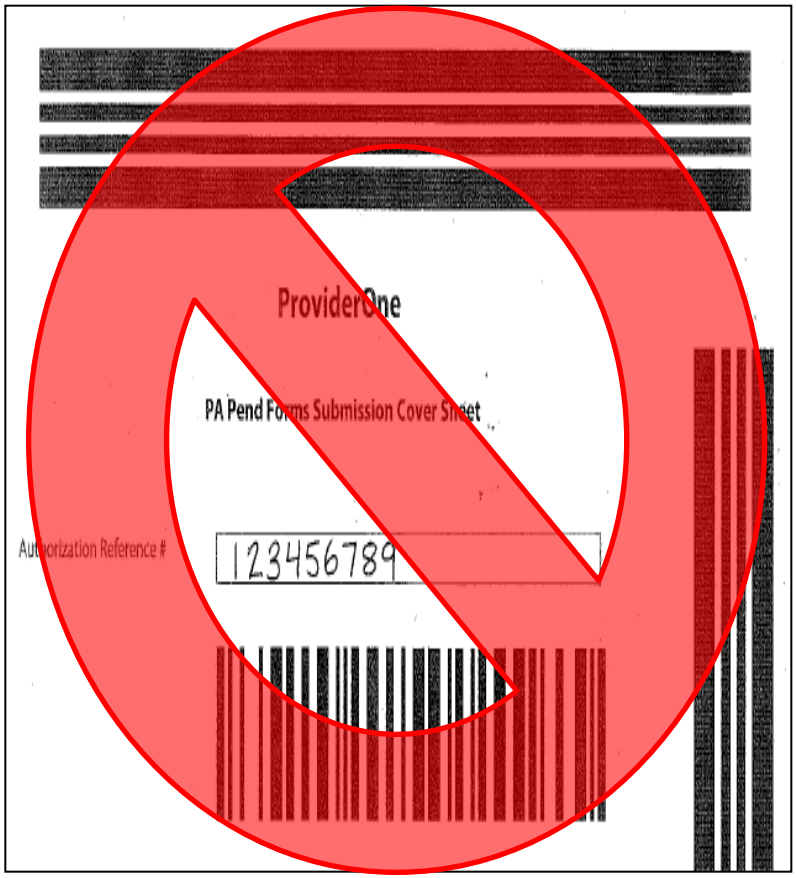
DO NOT USE FOR PHARMACY RELATED AUTHORIZATION REQUESTS!

Privacy Statement:
This material in this facsimile is intended only for the use of the individual who it is addressed and may contain information that is confidential, privileged and exempt from disclosure under applicable law.

HIPAA Compliance:
Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment to see insurance payment or to perform other specific health care operations.

FAX to : 1-866-668-1214.

THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET.



Cover Sheets are located at :
http://www.hca.wa.gov/medicaid/billing/pages/document_submission_cover_sheets.aspx

Washington State Health Care Authority

Spenddown

What is a Spenddown?

- An expense or portion of an expense which has been determined by the Agency to be a client liability.
- Expenses which have been assigned to meet a client liability are not reimbursed by the Agency.
- Spenddown liability is deducted from any payment due the provider.
- See WAC 388-519 for complete details.

Why does the client have a Spenddown?

- Applicant applies for the MN (Medically Needy Program).
  - ✓ Has income above MN limits for medical benefits.
  - ✓ Required to spend down excess income.
- Applicant spends down excess income by incurring medical bills.
- Client becomes eligible for Medicaid medical benefits once incurred medical bills equal the spenddown amount.

How does a Provider know if a Client has a Spenddown Liability?

- Review the client eligibility screen in ProviderOne.
  - ✓ Benefit inquiry indicates "Pending Spenddown, No Medical."
  - ✓ Spenddown balance will be displayed.
- Ask the Client for a copy of their **"award"** letter.
  - ✓ Identifies the medical bills.
  - ✓ Indicates dollar amounts client must pay.
- Call the spenddown customer service center at 1-877-501-2233.

How does a Provider know if a Client has a Spenddown Liability?

- The client benefit inquiry indicating **"Pending Spenddown – No Medical"** looks like this:

Client Eligibility Spans

Service Type Code	Insurance Type Code	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group
30: Health Benefit Plan Coverage	MC: Medicaid	Pending Spenddown - No Medical	08/01/2011	12/31/2999	S99

What is the Spenddown amount?

- The same eligibility check indicates the spenddown amount:

Spenddown Information Base Period - Start: 08/01/2011 End: 01/31/2012

Total Spenddown	Spenddown Liability	Remaining Spenddown	EMER Liability	Remaining EMER	Spenddown Status	Update Date	Spenddown Start
2022.00	2022.00	2022.00	0.00	0.00	Pending	08/09/2011	08/01/2011

- Contact the spenddown customer service center at 1-877-501-2233

When does a provider report the Spenddown amount on a claim?

- All providers must verify if the client has a spenddown if:
  - ✓ The client is on the LCP-MNP program.
  - ✓ The clients ACES Coverage Group Code ends with **"99"**.

Eligibility Start Date	Eligibility End Date	ACES Coverage Group
08/01/2011	12/31/2999	S99

✓ The claim DOS is the same as the client eligibility begin date.

- ✓ Call the spenddown customer service center at 1-877-501-2233.

When does a provider report the Spenddown amount on a claim?

- The agency checks the eligibility system (ACES) to see if the claim applies to the spenddown.
  - ✓ If claim applies and no spenddown is reported then the claim is denied.
  - ✓ If claim applies, spenddown must be reported accurately or the claim is denied.
  - ✓ If claim applies, spenddown is subtracted from service allowable and provider may be paid any difference.

What if the client has Medicare Primary and a Spenddown?

- QMB client eligibility
  - ✓ May have two active coverage segments at the same time.
    - The first segment is their QMB with the dates of coverage.
    - Second segment may be the **"Pending Spenddown"** with overlapping dates with the QMB segment.
  - ✓ Bill Medicare, then Medicaid as a crossover:
    - Medicaid may pay the crossover (depends on the Medicare paid amount).
    - Cannot bill the client for these balance amounts.
    - No spenddown amount to report on these claims.
  - ✓ Services not covered by Medicare are used to satisfy the spenddown **NOT** the crossover claim.

How does a provider report the Spenddown amount on a claim?

- CMS-1500
  - ✓ Electronic batch claims (837P)
    - HIPAA 5010, Loop 2300 in the
    - Patient Amount Paid segment
      - Use value qualifier F5 in AMT01
      - Then enter the $$ amount in AMT02
  - ✓ Paper claim enter the spenddown
    - In field 19, comments
    - Enter **Spenddown**
    - Then enter the $$ amount

When can a provider bill the client for their Spenddown amount?

- If your claim is on the award letter as part of the incurred expenses to meet the spenddown.
  - ✓ No award letter? Call 1-877-501-2233

- No waiver form is required to bill the client for their spenddown liability.
  - ✓ Can bill the client only for the spenddown liability amount not the balance of a claim if the Agency makes a payment.

When can a provider bill the Client?

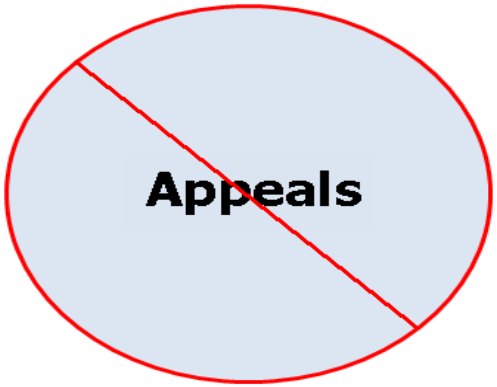
- Provider billed Medicaid for the services and the claim is denied as "Client pending spenddown."
- Client then satisfies spenddown and becomes Medicaid eligible.
- Provider is to check eligibility again before billing the client:
  - ✓ If client is now eligible, bill Medicaid.
  - ✓ If client is eligible and provider has billed client, they need to stop and bill Medicaid.
  - ✓ If the client is eligible and a claim should have been billed to Medicaid, do not send the client to collections but bill Medicaid.

When can a provider bill the Client?

- Client that satisfies spenddown and becomes Medicaid eligible, that eligibility is called retro eligibility.
- Per retro eligibility rules if client has paid anything, refund client and bill Medicaid.
- All billing the client rules apply.
- See the billing the client WAC 182-502-0160 for complete detailed information.

Claim Appeals

Claim Appeals



- We don't have an "appeal process" for denied claims.
- Fix the claim error causing claim denial and resubmit the claim.
- If you think the claim(s) were denied in error submit a work ticket online at https://fortress.wa.gov/hca/p1contactus/
- Work tickets average 25 days to process and complex tickets can take longer.

Billing a Client

LEARNING OBJECTIVES

As a result of this webinar providers will:

- Understand when a provider can and cannot bill a client for healthcare services.
- Know when a provider can bill a client without HCA form 13-879, titled *Agreement to Pay for Healthcare Services*.
- Know how to complete HCA form 13-879, and know when it is and is not required.

These rules apply only to providers who have completed a Core Provider Agreement (CPA) or are contracted with an Agency-contracted Managed Care Organization (MCO).

WHY THIS IS IMPORTANT

Following these rules may protect a provider from:

- Termination of CPA or MCO contracts
- Being excluded from participation in federal contracting, including Medicare
- Audit
- Fraud Charges and Prosecution

BACKGROUND

Effective for dates of service on and after May 27, 2010, Health Care Authority implemented revisions to Washington Administrative Code (WAC) 182-502-0160, *Billing a Client*, allowing providers, in limited circumstances, to bill fee-for-service or managed care clients for covered healthcare services, and allowing fee-for-service or managed care clients the option to self-pay for covered healthcare services.

The full text of WAC 182-502-0160 can be found at http://apps.leg.wa.gov/wac/default.aspx?cite=182-502.

PROVIDER RESPONSIBILITIES

- You must verify whether the client is eligible to receive medical assistance services on the date the services are provided.
- You must verify whether the client is enrolled with an Agency-contracted managed care organization (MCO).
- You must know the limitations of the services within the client's benefits package (see WAC 182-501-0050 (4)(a) and 182-501-0065) and inform the client of those limitations.

PROVIDER RESPONSIBILITIES

- Exhaust all applicable Agency or Agency-contracted MCO processes necessary to obtain authorization for a requested service.
- Ensure that translation or interpretation is provided to clients with limited English proficiency (LEP) who agree to be billed for services.
- Retain all documentation which demonstrates client and provider compliance with WAC, including any written and/or verbal agreements to pay for services, including your practice's own financial responsibility form.

DEFINITIONS

Healthcare Service Categories: The groupings of healthcare services listed in the table in WAC 182-501-0060. Healthcare service categories are included or excluded depending on the client's benefits package.

Benefits Package: The set of healthcare service categories included in a client's eligibility program.

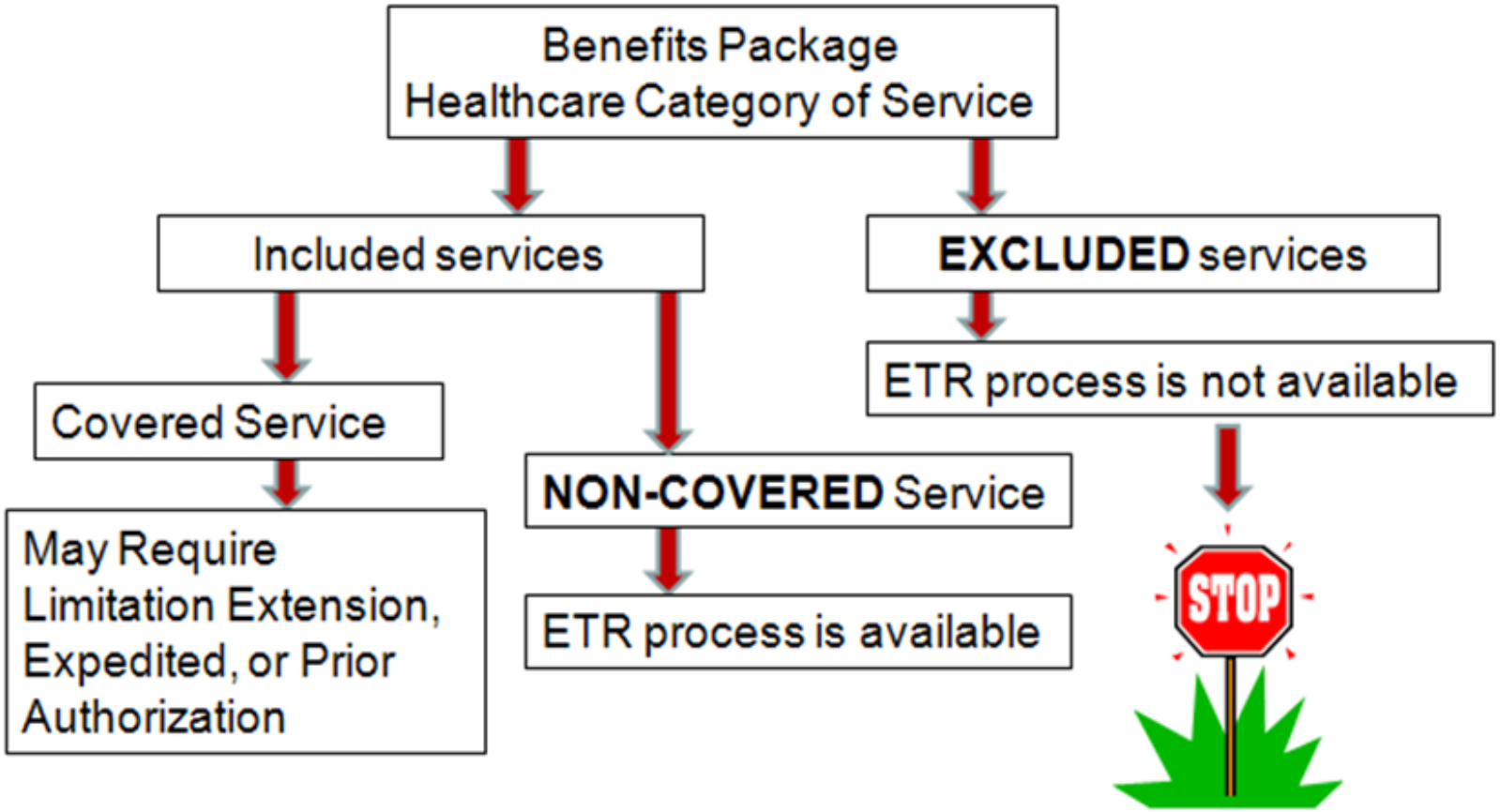
Excluded Services: A set of services that we do not include in the client's benefits package. There is no Exception to Rule (ETR) process available for these services.

DEFINITIONS

Covered service: A healthcare service contained within a "service category" that is included in a medical assistance benefits package described in WAC 182-501-0060.

Non-covered service: A specific healthcare service contained within a service category that is included in a medical assistance benefits package, for which the Agency does not pay without an approved Exception to Rule (see WAC 182-501-0160). A **non-covered** service is not the same as an **excluded** service (see WAC 182-501-0060). Non-covered services are identified in WAC 182-501-0070 and in specific healthcare program rules.

NON-COVERED VS. EXCLUDED



NON-COVERED VS. EXCLUDED

Non-Covered	Excluded for Adults* (no funding for these services)
Cosmetic surgery • Physician services are covered, however cosmetic surgery is not covered under the client's benefits package.	Adult Vision Hardware
Hairpieces or wigs • DME services are covered, however wigs are not covered under the DME benefits package.	Adult Hearing Hardware
Upright MRI • Diagnostic procedures are covered, but this specific procedure is not covered after a health technology review of its efficacy.	* 21 years of age and older
ETR CAN BE REQUESTED	**NO ETR PROCESS AVAILABLE**

WHEN FORM 13-879 IS NOT REQUIRED

- The client, the client's legal guardian, or the client's legal representative was reimbursed for the service directly by a third party, or refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third party insurance carrier for the service.
- The client represented him or herself as a private pay client, with no medical assistance coverage (FFS or MCO) while currently eligible for and receiving benefits under Washington Apple Health (Medicaid).

WHEN FORM 13-879 IS NOT REQUIRED

- The bill counts toward the financial obligation of the client or applicant [such as spenddown liability, client participation (as described in WAC 182-513-1380), emergency medical expense requirement, deductible, or copayment required by the Agency].
- The client is under the Agency's or an Agency-contracted MCO's Patient Review & Coordination (PRC) program (WAC 182-501-0135) and receives nonemergency services from providers or healthcare facilities other than those to whom the client is assigned or referred under the PRC program.

WHEN FORM 13-879 IS NOT REQUIRED

- The services were non-covered ambulance services [see WAC 182-546-0250(2)].
- The services were provided to a Take Charge – Family Planning Only (TCFPO) client, and the services are not within the scope of the client's benefits package.
- An Agency-contracted MCO enrollee chooses to receive nonemergency services from providers outside of the MCO's network without authorization from the MCO.

WHEN FORM 13-879 IS NOT REQUIRED

- A provider can bill an adult client for **excluded** services, i.e., vision hardware or hearing devices
- Please discuss with the client if the service they are requesting is no longer paid for by the Agency so they can make an informed decision as to what costs they may incur

WHEN FORM 13-879 MUST BE USED

- If the service is not covered, the provider must inform the client of his or her right to have the provider request an ETR, and the client chooses not to have the provider request an ETR.
- The service is not covered by the Agency, the provider requests an ETR and the ETR process is exhausted, and the service is denied.

WHEN FORM 13-879 MUST BE USED

- The service is covered only with prior authorization; all the requirements for obtaining authorization were completed but the authorization was denied; the client completes the administrative hearings process or foregoes any part of it; and the service remains denied by the Agency as not medically necessary.
- The service is covered by the Agency without prior authorization; the service is provided based on the client's personal preference which the Agency does not pay for; and the client completes the administrative hearings process or chooses to forego any part of it.

WHEN A CLIENT CAN NEVER BE BILLED

A client can never be billed, with or without Form 13-879, in the following situations:

- Services for which the provider did not correctly bill the Agency or MCO.
- If the Agency or MCO returns or denies a claim for correction and resubmission, the client cannot be billed.

For directions on billing fee-for-service, see the *ProviderOne Billing & Resource Guide*. For directions on how to bill a client's MCO, please contact the plan directly.

WHEN A CLIENT CANNOT BE BILLED

- Services for which the Agency or MCO denied the authorization because the process was placed on hold pending receipt of requested information, and the requested information was never received by the Agency (WAC 182-501-0165(7)(c)(i)). This includes authorization requests that are returned due to missing required information ("rejected" status).
- The cost difference between an authorized service or item and an "upgraded" service or item preferred by the client (*e.g.*, a wheelchair with more features, or brand name drugs versus generic drugs).

WHEN A CLIENT CANNOT BE BILLED

- Copying, printing, or otherwise transferring healthcare information, as the term healthcare information is defined in Chapter 70.02 RCW, to another healthcare provider, which includes, but is not limited to medical/dental charts, radiological or imaging films, and laboratory or other diagnostic test results
- Missed, cancelled, or late appointments
- Shipping and/or postage charges

WHEN A CLIENT CANNOT BE BILLED

- Services for which the provider has not received payment from the Agency or the client's MCO because the provider did not complete all requirements necessary to obtain payment (*e.g.*, billing using a diagnosis code which is not a primary ICD-9 diagnosis).
- "Boutique", "concierge", or other enhanced services (*e.g.*, newsletters, 24-hour access to provider, health seminars) as a condition for access to care.

Providers are prohibited from "balance billing" a client, *i.e.*, charging the difference between usual, customary rates and the Agency's payment.

FORM 13-879 (FRONT)

Washington State Health Care Authority

Agreement to Pay for Healthcare Services

WAC 182-502-0160 ("Billing a Client")

This is an agreement between a "client" and a "provider," as defined below. The client agrees to pay the provider for healthcare service(s) that the Health Care Authority (HCA) will not pay. Both parties must sign this Agreement. For the purposes of this Agreement, "services" include but are not limited to healthcare treatment, equipment, supplies, and medications.

Client - A recipient of Medicaid or other healthcare benefits through the HCA or a managed care organization (MCO) that contracts with the HCA.
Provider - An institution, agency, business, or person that provides healthcare services to HCA clients and has a signed agreement with the HCA or authorization from an MCO.

This Agreement and WAC 182-502-0160 apply to billing a client for covered and noncovered services as described in WAC 182-501-0050 through WAC 182-501-0070. Providers may not bill any HCA client (including those enrolled with an MCO that contracts with the HCA) for services which the HCA or an MCO that contracts with the HCA may have paid until the provider has completed all requirements for obtaining authorization.

CLIENT'S PRINTED NAME	CLIENT'S ID NUMBER
PROVIDER'S PRINTED NAME	PROVIDER NUMBER

Directions:

- Both the provider and the client must fully complete this form **before** an HCA client receives any service for which this Agreement is required.
- You must complete this form no more than 90 calendar days before the date of the service. If the service is not provided within 90 calendar days, the provider and client must complete and sign a new form.
- The provider and the client must complete this form only **after** they exhaust all applicable HCA or HCA-contracted MCO processes which are necessary to obtain authorization for the requested service(s). These may include the exception to rule (ETR) process for noncovered services as described in WAC 182-501-0160 or the administrative hearing process, if the client chooses to pursue these processes.
- Limited English proficient (LEP) clients must be able to understand this form in their primary language. This may include a translated form or interpretation of the form. If the form is interpreted for the client, the interpreter must also sign and date the form. Both the client and the provider must sign a translated form.

Fully complete the table on back of this form. If needed, attach another sheet for additional services. The client, provider, and interpreter (if applicable) must sign and date each additional page.

Important Note from HCA:

- This agreement is void and unenforceable if the provider fails to comply with the requirements of this form and WAC 182-502-0160 or does not satisfy HCA conditions of payment as described in applicable Washington Administrative Code (WAC) and Billing Instructions. The provider must reimburse the client for the full amount paid by the client.
- See WAC 182-502-0160(9) for a list of services that cannot be billed to a client, regardless of a written agreement.
- Keep the original agreement in the client's medical record for 6 years from the date this agreement is signed. Give a copy of this completed, signed agreement to the client.
- Providers are responsible for ensuring that translation or interpretation of this form and its content is provided to LEP clients. Translated forms are available at http://hrsa.dshs.wa.gov/mpforms.shtml.

FORM 13-879 (BACK)

SPECIFIC SERVICE(S) OR ITEM(S) TO BE PROVIDED AND ANTICIPATED DATE OF SERVICE	CPT/CDT/ HCPC CODE (BILLING CODE)	AMOUNT TO BE PAID BY CLIENT	REASON WHY THE CLIENT IS AGREEING TO BE BILLED (CHECK THE ONE THAT APPLIES FOR EACH SERVICE)	COVERED TREATMENT ALTERNATIVES OFFERED BUT NOT CHOSEN BY CLIENT	DATE(S) ETR/NFJ REQUESTED/DENIED OR WAIVED, OR PRIOR AUTHORIZATION (PA) REQUESTED/DENIED, IF APPLICABLE	
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Non-formulary drug, NFJ waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for ☐ Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Non-formulary drug, NFJ waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for ☐ Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Non-formulary drug, NFJ waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for ☐ Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)

- I understand that HCA or an MCO that contracts with HCA will not pay for the specific service(s) being requested for one of the following reasons, as indicated in the above table: 1) HCA does not cover the service(s); 2) the service(s) was denied as not medically necessary for me, or 3) the service(s) is covered but the type I requested is not.
- I understand that I can, but may choose not to: 1) ask for an Exception to Rule (ETR) after an HCA or HCA-contracted MCO denial of a request for a noncovered service; 2) submit a Non-Formulary Justification (NFJ) with the help of my prescriber fro a non-formulary medication; or 3) ask for a hearing to appeal an HCA or HCA-contracted MCO denial of a requested service.
- I have been fully informed by this provider of all available medically appropriate treatment, including services that may be paid for by the HCA or an HCA-contracted MCO, and I still choose to get the specified service(s) above.
- I understand that HCA does not cover services ordered by, prescribed by, or are a result of a referral from a healthcare provider who is not contracted with HCA as described in Chapter 182-502 WAC.
- ***I agree to pay the provider directly for the specific service(s) listed above.***
- I understand the purpose of this form is to allow me to pay for and receive service(s) for which HCA or an HCA-contracted MCO will not pay. This provider answered all my questions to my satisfaction and has given me a completed copy of this form.
- I understand that I can call HCA at 1-800-562-3022 to receive additional information about my rights or services covered by HCA under fee-for-service or managed care.

I AFFIRM: I understand and agree with this form's content, including the bullet points above.	CLIENT'S OR CLIENT'S LEGAL REPRESENTATIVE'S SIGNATURE	DATE
I AFFIRM: I have complied with all responsibilities and requirements as specified in WAC 182-502-0160.	PROVIDER OF SERVICE(S) SIGNATURE	DATE
I AFFIRM: I have accurately interpreted this form to the best of my ability for the client signing above.	INTERPRETER'S PRINTED NAME AND SIGNATURE	DATE

NOTES ON FORM 13-879

- The form must be completed no more than 90 days before the services are provided.
- Keep the original agreement in the client's medical record for six years from the date it is signed.
- A copy of this agreement must be given to the client.
- This form is available in eight different languages; use the appropriate version for non-English speakers (contact the Agency for languages not listed).
- Use an interpreter, when necessary, to ensure client understands all his or her options and is able to make an informed decision.

SCENARIOS

A new client comes in for an appointment and documents she has no insurance when completing her registration. The client:

a) Can be billed without HCA form 13-879
b) Can be billed with HCA form 13-879
c) Cannot be billed for this service

SCENARIOS

A new client comes in for an appointment and documents she has no insurance when completing her registration. The client:

a) Can be billed without HCA form 13-879
b) Can be billed with HCA form 13-879
c) Cannot be billed for this service

A client who represents herself as a self-pay patient can be billed without Form 13-879. Keep documentation of this lack of coverage in your records and give a copy to the client.

SCENARIOS

A provider's claim is denied by the Agency for missing or invalid taxonomy. The client:

a) Can be billed without HCA form 13-879
b) Can be billed with HCA form 13-879
c) Cannot be billed for this service

SCENARIOS

A provider's claim is denied by the Agency for missing or invalid taxonomy. The client:

a) Can be billed without HCA form 13-879
b) Can be billed with HCA form 13-879
c) Cannot be billed for this service

Clients cannot be billed for denied claims that need to be corrected and resubmitted to the Agency.

SCENARIOS

An adult client with the Limited Casualty Program – Medically Needy Program (LCP-MNP) Benefits Package goes to see a physical therapist, but physical therapy is excluded from the LCP-MNP benefits package. The client:

a) Can be billed without HCA form 13-879
b) Can be billed with HCA form 13-879
c) Cannot be billed for this service

SCENARIOS

An adult client with the Limited Casualty Program – Medically Needy Program (LCP-MNP) Benefits Package goes to see a physical therapist, but physical therapy is excluded from the LCP-MNP benefits package. The client:

a) Can be billed without HCA form 13-879
b) Can be billed with HCA form 13-879
c) Cannot be billed for this service

Clients can be billed for excluded services without completing Form 13-879.

SCENARIOS

A new client comes in for an appointment, states she has Medicaid, but does not have her Client Services card available. The client:

a) Can be billed without HCA form 13-879
b) Can be billed with HCA form 13-879
c) Cannot be billed for this service

SCENARIOS

A new client comes in for an appointment, states she has Medicaid, but does not have her Client Services card available. The client:

a) Can be billed without HCA form 13-879
b) Can be billed with HCA form 13-879
c) Cannot be billed for this service

There are many ways to check eligibility other than using the ProviderOne Client Services Card. Please visit the ProviderOne Billing and Resource Guide for more information on checking eligibility.

SCENARIOS

An adult client goes in for a routine physical with no medical concerns. The client:

a) Can be billed without HCA form 13-879
b) Can be billed with HCA form 13-879
c) Cannot be billed for this service

SCENARIOS

An adult client goes in for routine physical with no medical concerns (which the Agency does not cover). The client:

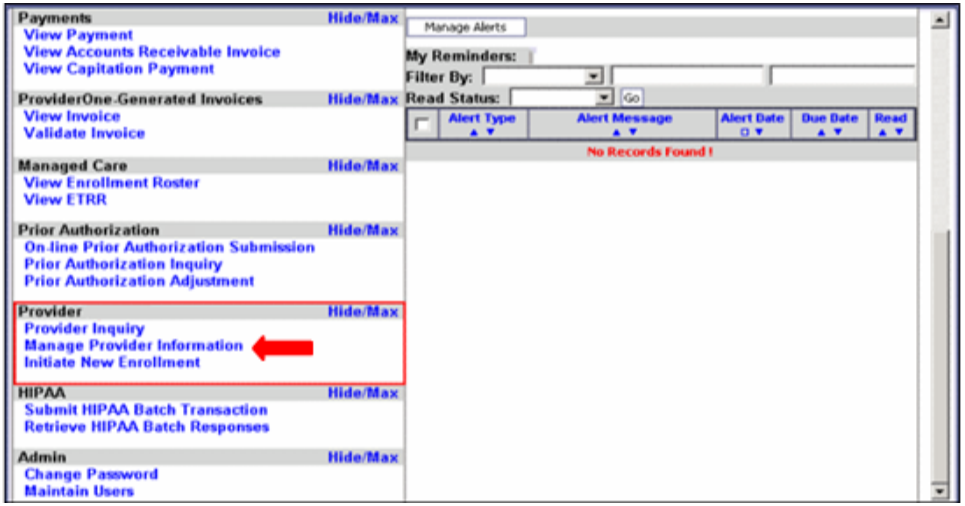
a) Can be billed without HCA form 13-879
b) Can be billed with HCA form 13-879
c) Cannot be billed for this service

While some services during the exam may be covered, the exam itself may be non-covered if billed as a routine physical. A client can be billed for these services after completing form 13-879.

Provider File Maintenance

Provider File Maintenance

- Modifying Provider File Information
  - ✓ Log into ProviderOne with the **Provider File Maintenance** or **Supers User** profile.
  - ✓ Click on the **Manage Provider Information** hyperlink



Provider Types include:

- ✓ Individual
- ✓ Group
- ✓ Tribal
- ✓ Facilities (FAOI)
- ✓ Servicing

  - ✓ Go to web page http://hrsa.dshs.wa.gov/provider/provideronemanuals.shtml for the different of provider file update modification manuals.

Provider File Maintenance

- Modifying Provider File Information
  - ✓ The Business Process Wizard contains the steps for modification. Click on the step hyperlink to modify.

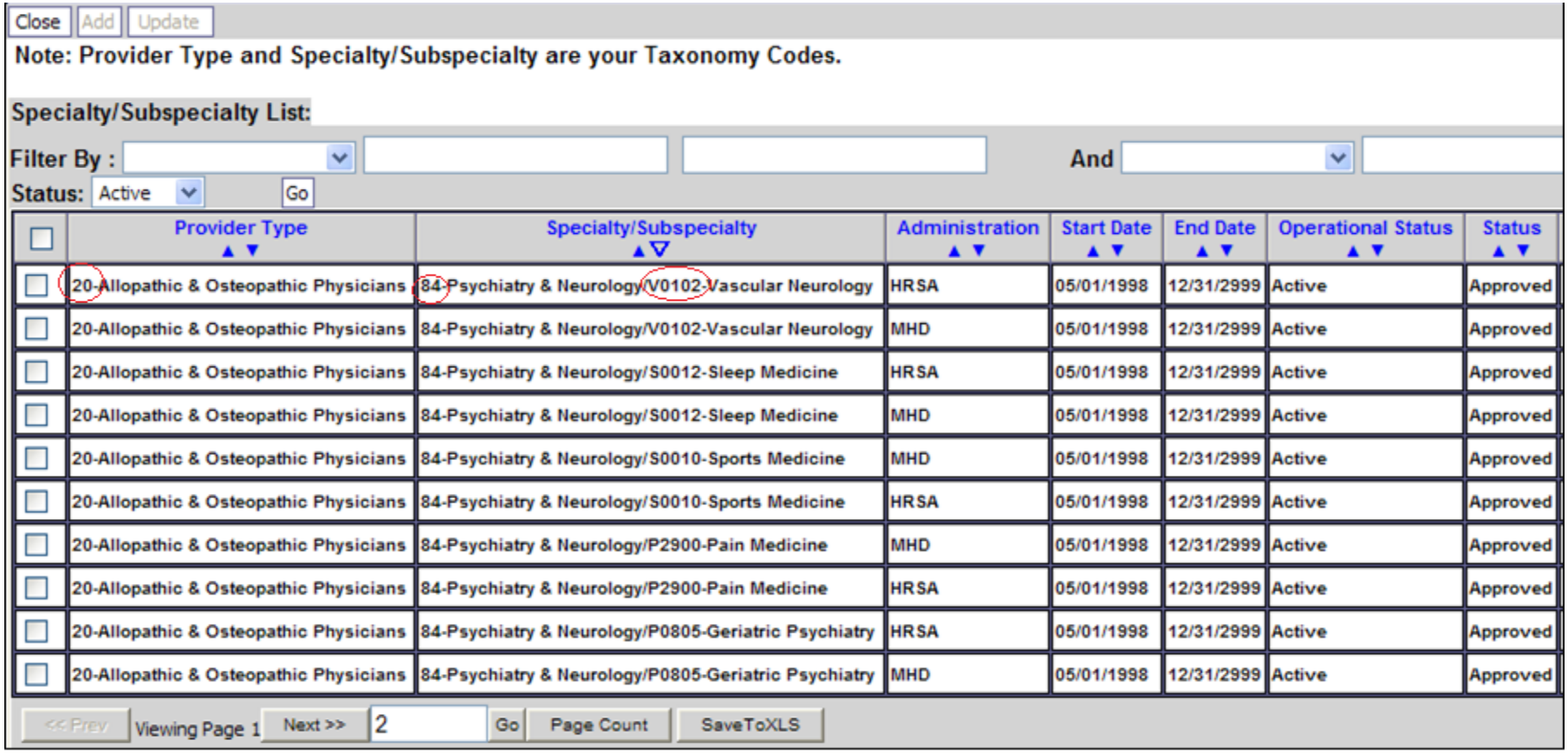
View/Update Provider Data - Group Practice:

Business Process Wizard - Provider Data Modification (Group Practice). In order to finalize submission of your requested changes, you must c

Step	Required	Last Modification Date	Last Review Date	Status
Step 1: Basic Information	Required	09/30/2009	09/30/2009	Complete
Step 2: Locations	Required	09/30/2009	09/30/2009	Complete
Step 3: Specializations	Required	06/15/2010	07/22/2010	Complete
Step 4: Ownership Details	Required	09/30/2009	09/30/2009	Complete
Step 5: Licenses and Certifications	Required	06/15/2010	07/22/2010	Complete
Step 6: Training and Education	Optional	09/30/2009	09/30/2009	Complete
Step 7: Identifiers	Optional	09/30/2009	09/30/2009	Complete
Step 8: Contract Details	Optional	09/30/2009	09/30/2009	Complete
Step 9: Federal Tax Details	Required	09/30/2009	09/30/2009	Complete
Step 10: Invoice Details	Optional	09/30/2009	09/30/2009	Complete
Step 11: EDI Submission Method	Optional	09/30/2009	09/30/2009	Complete
Step 12: EDI Billing Software Details	Optional	09/30/2009	09/30/2009	Complete
Step 13: EDI Submitter Details	Required	01/19/2011	01/19/2011	Complete
Step 14: EDI Contact Information	Optional	05/10/2010	05/10/2010	Complete
Step 15: Servicing Provider Information	Required	08/31/2011	09/06/2011	Complete
Step 16: Payment Details	Required	09/30/2009	09/30/2009	Complete
Step 17: Submit Modification for Review	Required	09/30/2009	09/30/2009	Complete

Provider File Maintenance

- Step 3:Specializations (Taxonomy Codes)



Close | Add | Update

Note: Provider Type and Specialty/Subspecialty are your Taxonomy Codes.

Specialty/Subspecialty List:

Filter By : And

Status: Active Go

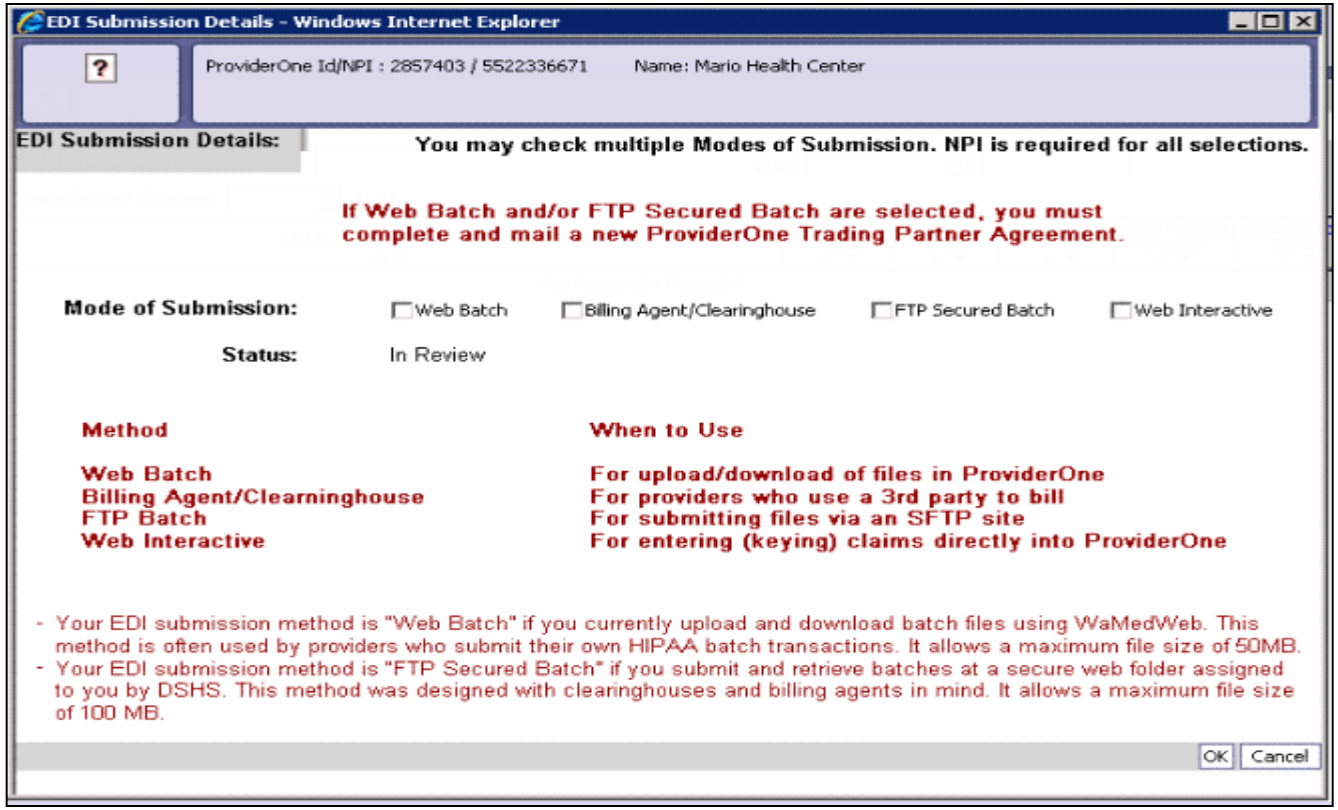
Provider Type	Specialty/Subspecialty	Administration	Start Date	End Date	Operational Status	Status
20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/V0102-Vascular Neurology	HRSA	05/01/1998	12/31/2999	Active	Approved
20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/V0102-Vascular Neurology	MHD	05/01/1998	12/31/2999	Active	Approved
20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/S0012-Sleep Medicine	HRSA	05/01/1998	12/31/2999	Active	Approved
20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/S0012-Sleep Medicine	MHD	05/01/1998	12/31/2999	Active	Approved
20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/S0010-Sports Medicine	MHD	05/01/1998	12/31/2999	Active	Approved
20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/S0010-Sports Medicine	HRSA	05/01/1998	12/31/2999	Active	Approved
20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/P2900-Pain Medicine	MHD	05/01/1998	12/31/2999	Active	Approved
20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/P2900-Pain Medicine	HRSA	05/01/1998	12/31/2999	Active	Approved
20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/P0805-Geriatric Psychiatry	HRSA	05/01/1998	12/31/2999	Active	Approved
20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/P0805-Geriatric Psychiatry	MHD	05/01/1998	12/31/2999	Active	Approved

<< Prev Viewing Page 1 Next >> 2 Go Page Count SaveToXLS

- ✓ The first specialization taxonomy code is 20-84-V0102 then add a "**X**" to all or (2084V0102X).

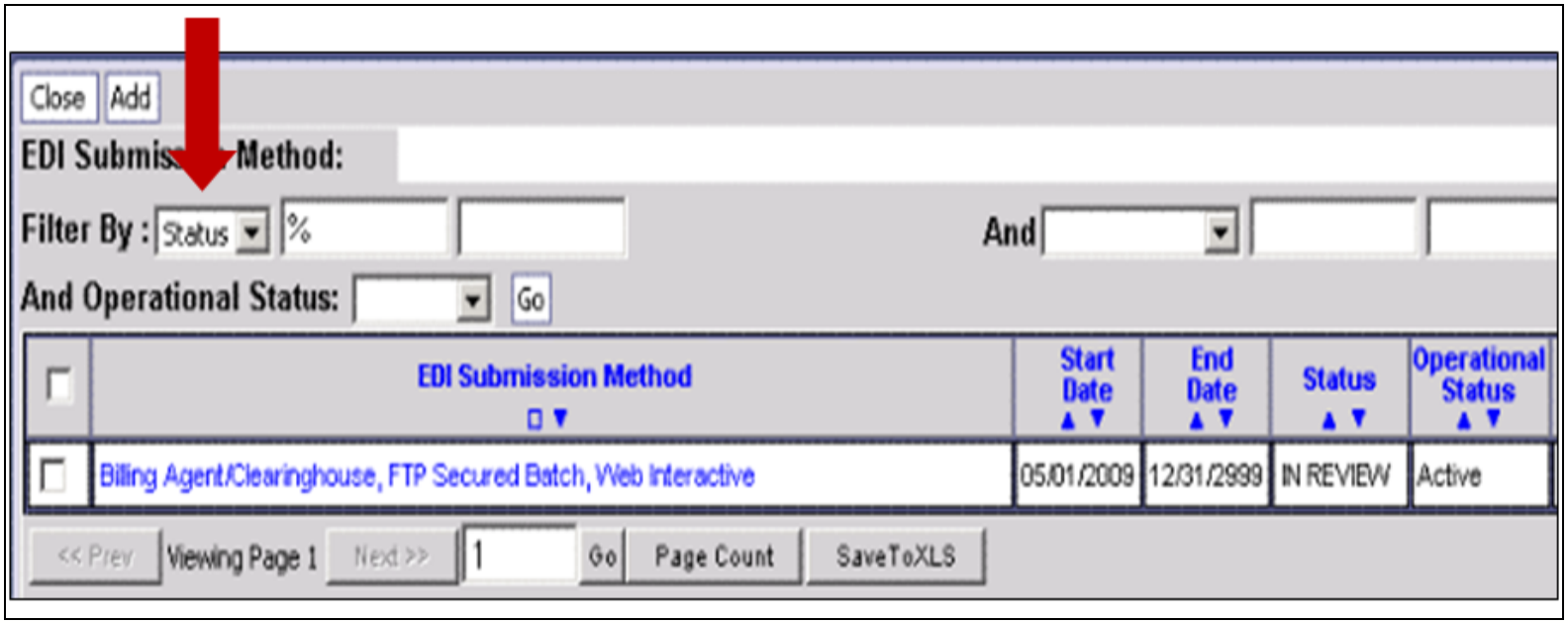
Provider File Maintenance

- Step 11:EDI Submission Method
  - ✓ How are you going to bill us?



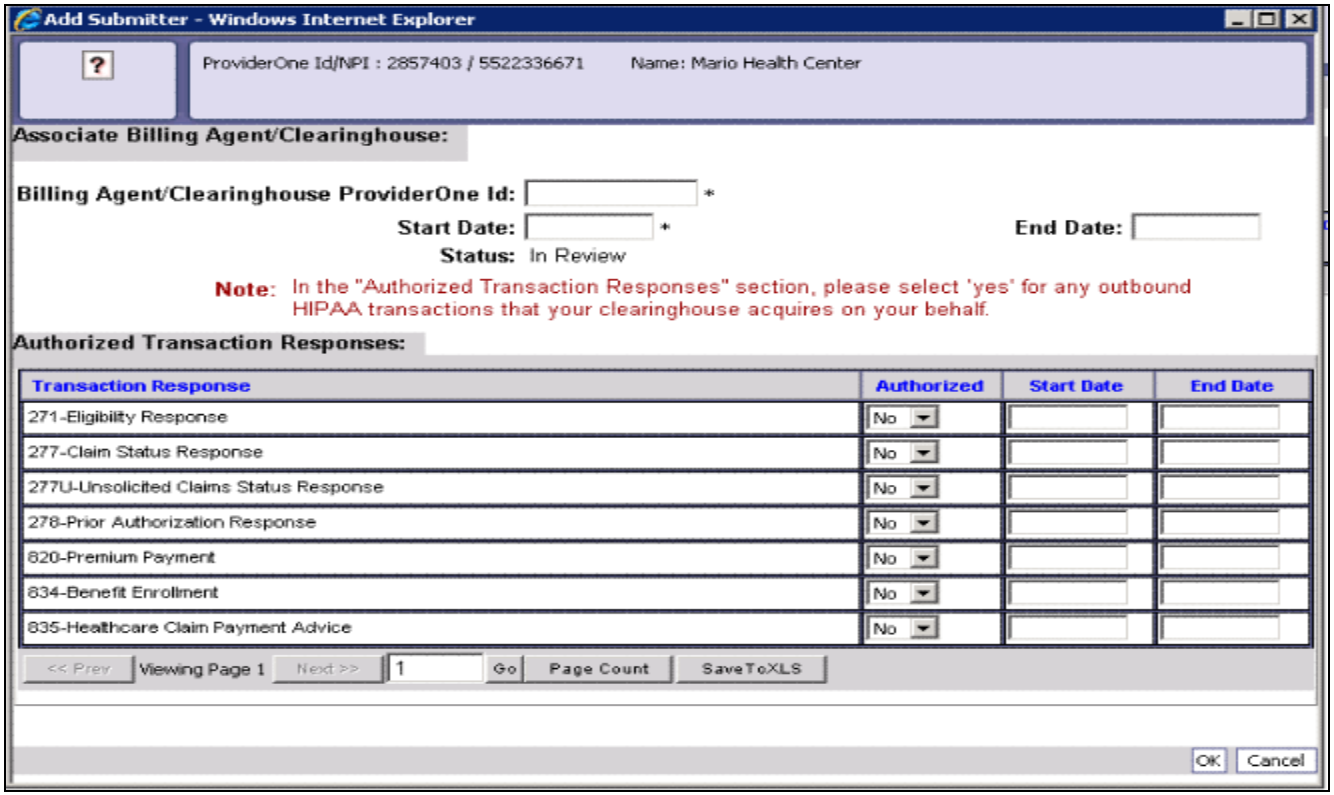
Provider File Maintenance

- Step 11:EDI Submission Method
  - ✓ Filter By: Status then add % and click



Provider File Maintenance

- Step 13:EDI Submitter Details.

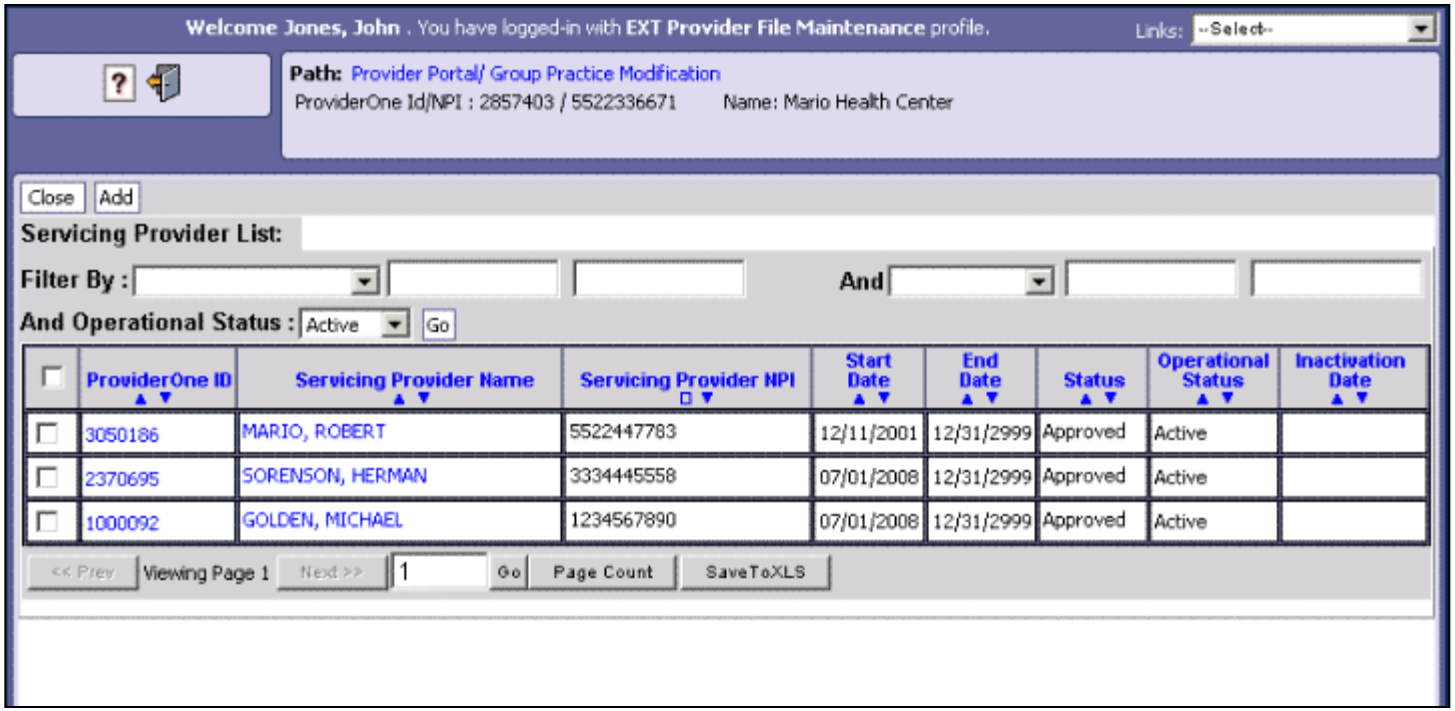


http://www.hca.wa.gov/medicaid/hipaa/pages/index.aspx

Washington State Health Care Authority

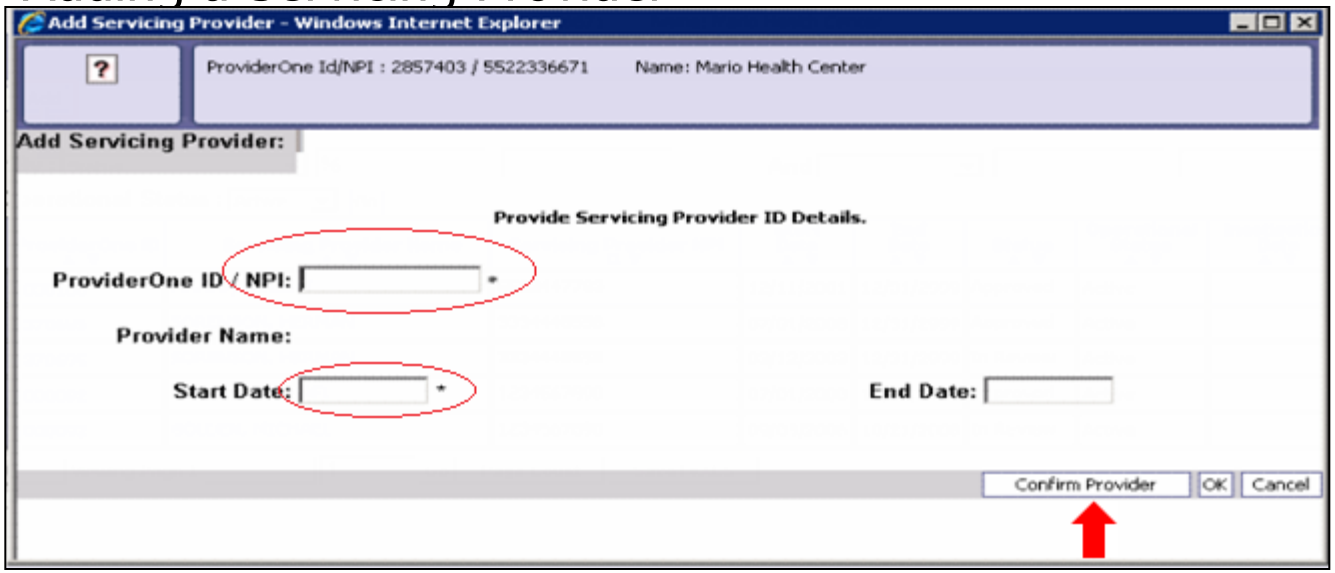
Provider File Maintenance

- Step 15: Servicing Provider Information



Provider File Maintenance

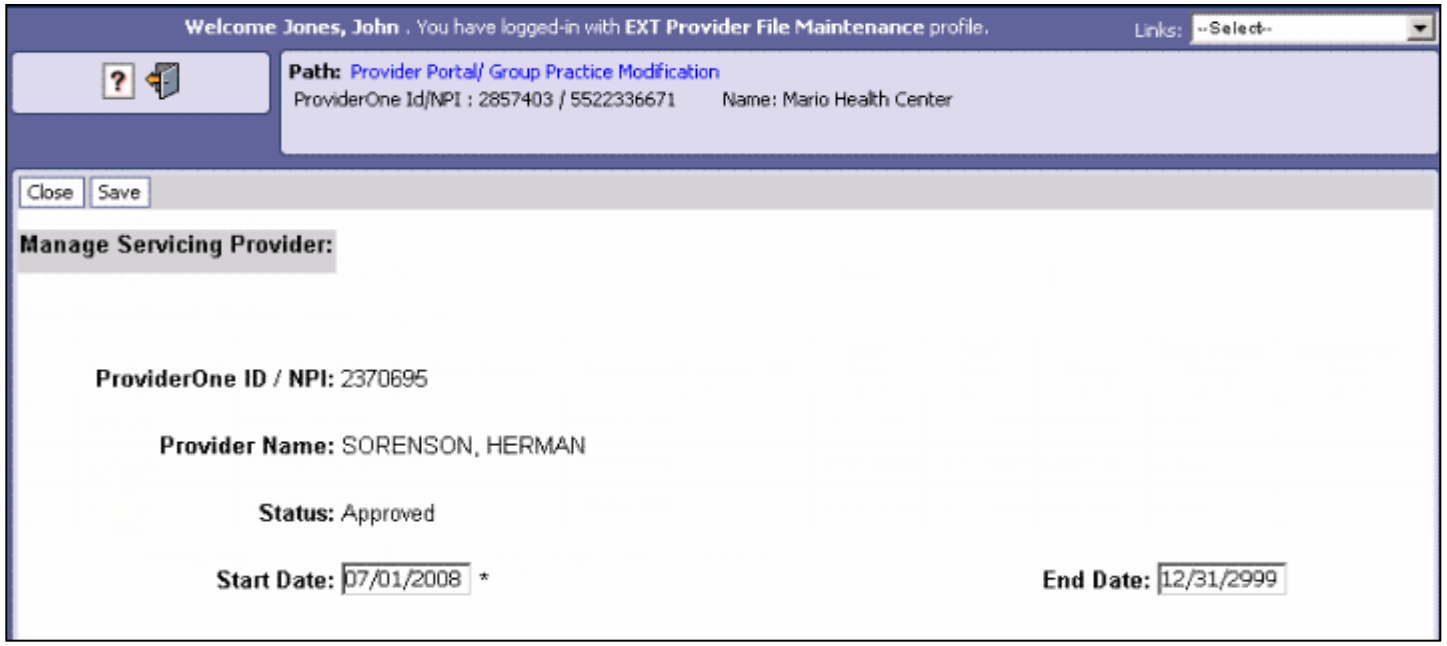
- Step 15: Servicing Provider Information
  - ✓ Adding a Servicing Provider



  - ✓ Enter the providers NPI number and start date at your clinic
  - ✓ Click on the Confirm Provider button

Provider File Maintenance

- Step 15:Servicing Provider Information
  - ✓ Ending a provider association



  - ✓ Enter an end date then save the change

Washington State Health Care Authority

Provider File Maintenance

- Step 15:Servicing Provider Information
  - ✓ Viewing a Servicing Providers taxonomy codes

Close | Required Credentials | Undo Update

Important - Step 11: EDI Submission Method is REQUIRED if FTP/Web Batch Submitter or Retrieving 835s.

View/Update Provider Data: Individual:

Servicing Provider Business Process Wizard

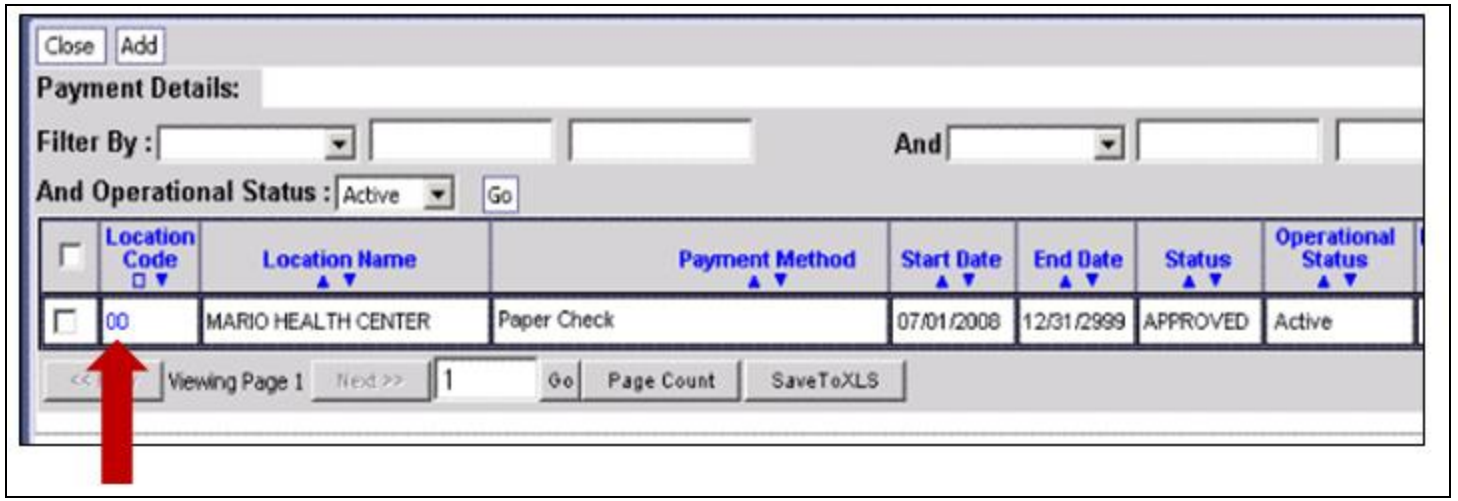
Business Process Wizard - Provider Data Modification (Individual). In order to finalize submission of your requested changes, you must comple

Step	Required	Last Modification Date	Last Review Date	Status
Step 1: Basic Information	Required	11/06/2010	11/06/2010	Complete
Step 2: Locations	Not Required	11/06/2010	11/06/2010	Complete
Step 3: Specializations	Required	11/06/2010	11/06/2010	Complete
Step 4: Ownership Details	Not Required	11/06/2010	11/06/2010	Complete
Step 5: Licenses and Certifications	Required	11/06/2010	11/06/2010	Complete
Step 6: Training and Education	Optional	11/06/2010	11/06/2010	Complete
Step 7: Identifiers	Optional	11/06/2010	11/06/2010	Complete
Step 8: Contract Details	Not Required	11/06/2010	11/06/2010	Complete
Step 9: Federal Tax Details	Optional	11/06/2010	11/06/2010	Complete
Step 10: Invoice Details	Not Required	11/06/2010	11/06/2010	Complete
Step 11: EDI Submission Method	Not Required	11/06/2010	11/06/2010	Complete
Step 12: EDI Billing Software Details	Not Required	11/06/2010	11/06/2010	Complete
Step 13: EDI Submitter Details	Not Required	11/06/2010	11/06/2010	Complete
Step 14: EDI Contact Information	Not Required	11/06/2010	11/06/2010	Complete
Step 15: Billing Provider Details	Optional	11/06/2010	11/06/2010	Complete
Step 16: Payment Details	Not Required	11/06/2010	11/06/2010	Complete
Step 17: View Union Information	Required	11/06/2010	11/06/2010	Complete
Step 18: Submit Modification for Review	Required	11/06/2010	11/06/2010	Complete

  - ✓ Click on Step 3: Specializations to see the taxonomy

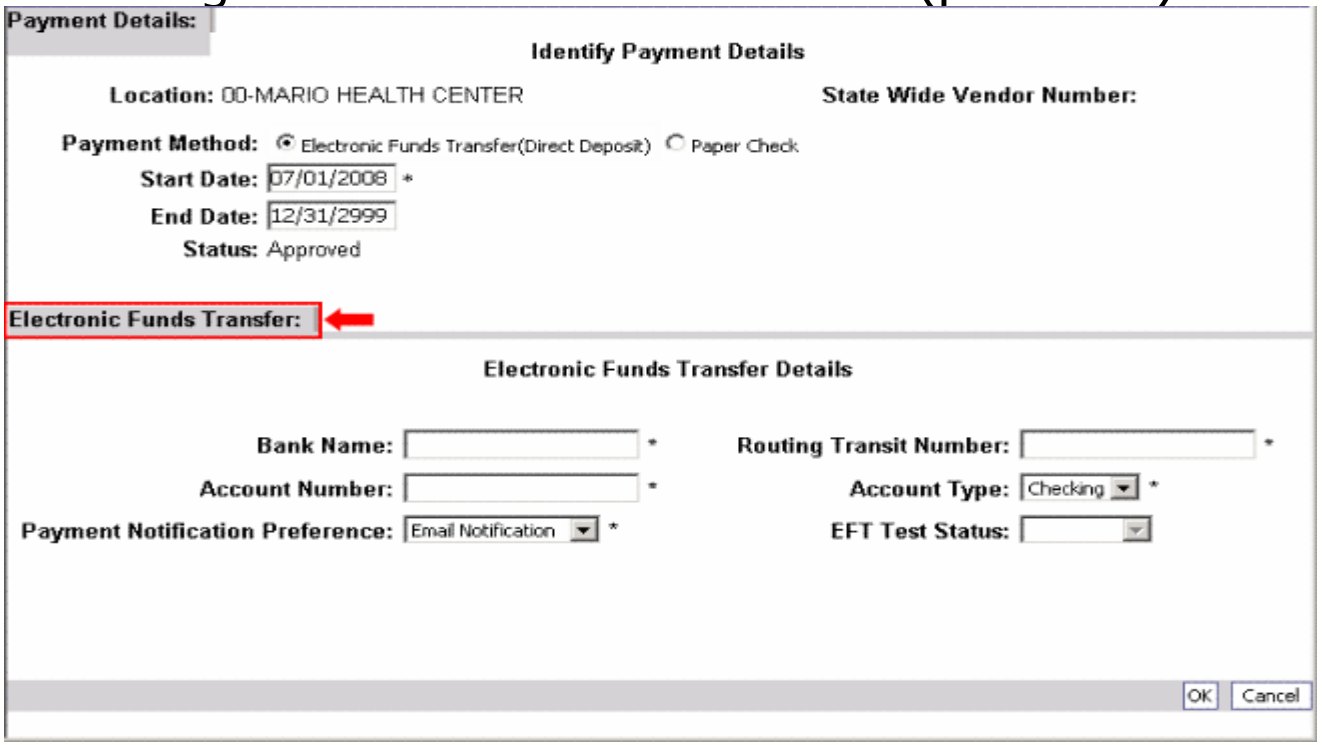
Provider File Maintenance

- Step 16:Payment Details
  - ✓ Displayed is current payment information.
  - ✓ To modify click on the "**00**".



Provider File Maintenance

- Step 16: Payment Details
  - ✓ Switching to Electronic Funds Transfer (preferred)



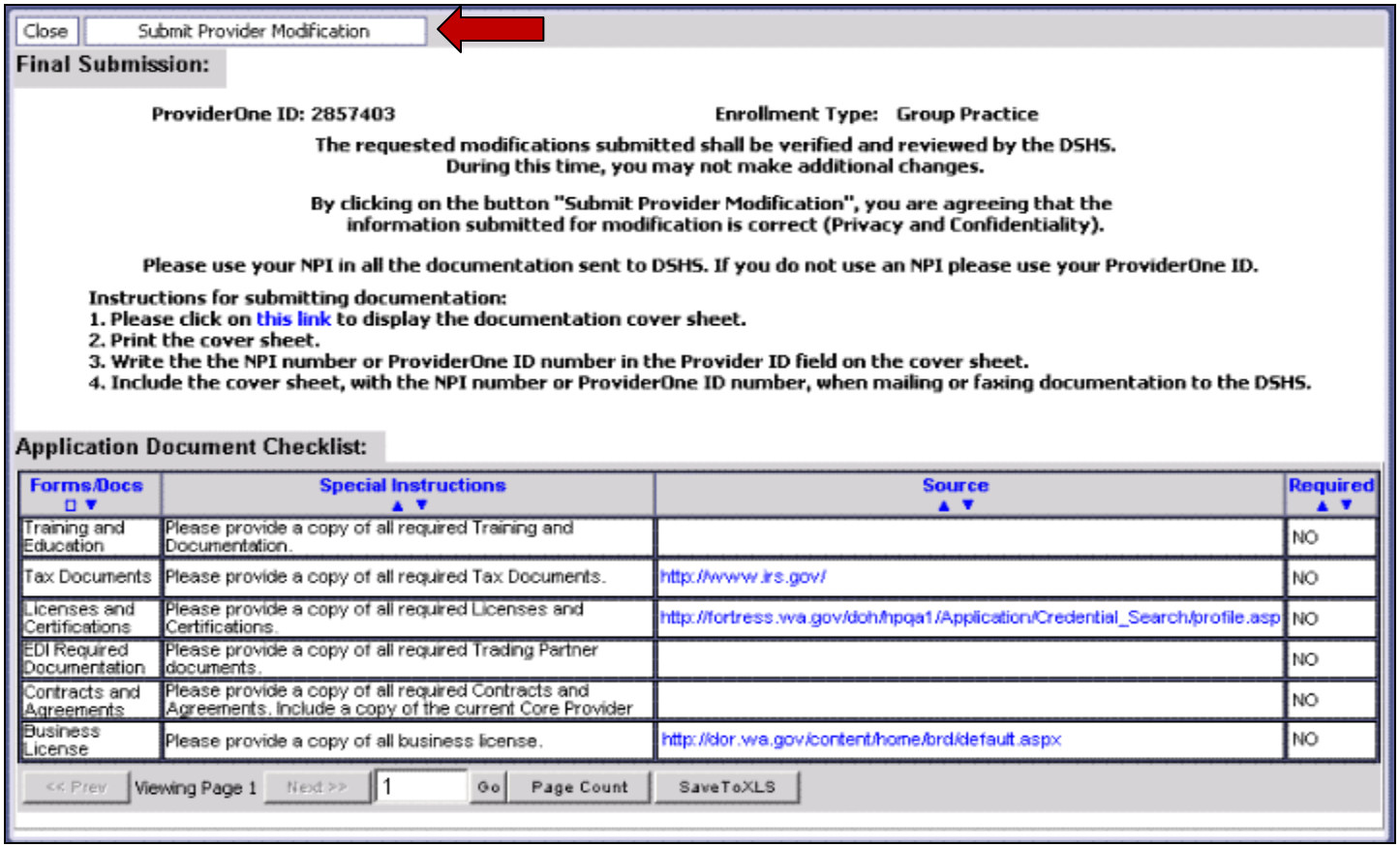
  - ✓ Enter your banking information then click **"OK"**

Provider File Maintenance

- Step 16:Payment Details
  - ✓ Fill out the Authorization Agreement for Electronic Funds Transfer form
  - ✓ Have the form signed
  - ✓ Fax in to 360-725-2144; or
  - ✓ Mail to address on the form
  - ✓ http://www.hca.wa.gov/medicaid/providerenroll/pages/enroll.aspx#provider

Provider File Maintenance

- Step 17:Submit Modification for Review



Close | Submit Provider Modification

Final Submission:

ProviderOne ID: 2857403 **Enrollment Type: Group Practice**

The requested modifications submitted shall be verified and reviewed by the DSHS. During this time, you may not make additional changes.

By clicking on the button "Submit Provider Modification", you are agreeing that the information submitted for modification is correct (Privacy and Confidentiality).

Please use your NPI in all the documentation sent to DSHS. If you do not use an NPI please use your ProviderOne ID.

Instructions for submitting documentation:
1. **Please click on this link to display the documentation cover sheet.**
2. **Print the cover sheet.**
3. **Write the the NPI number or ProviderOne ID number in the Provider ID field on the cover sheet.**
4. **Include the cover sheet, with the NPI number or ProviderOne ID number, when mailing or faxing documentation to the DSHS.**

Application Document Checklist:

Forms/Docs	Special Instructions	Source	Required
Training and Education	Please provide a copy of all required Training and Documentation.		NO
Tax Documents	Please provide a copy of all required Tax Documents.	http://www.irs.gov/	NO
Licenses and Certifications	Please provide a copy of all required Licenses and Certifications.	http://fortress.wa.gov/doh/hpqa1/Application/Credential_Search/profile.asp	NO
EDI Required Documentation	Please provide a copy of all required Trading Partner documents.		NO
Contracts and Agreements	Please provide a copy of all required Contracts and Agreements. Include a copy of the current Core Provider		NO
Business License	Please provide a copy of all business license.	http://dor.wa.gov/content/home/brd/default.aspx	NO

<< Prev | Viewing Page 1 | Next >> | 1 | Go | Page Count | SaveToXLS

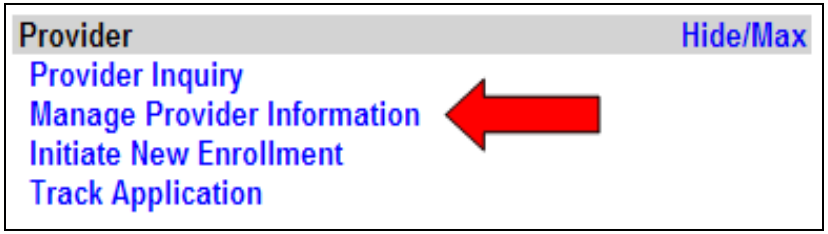
Provider File Maintenance

- More information on provider file maintenance visit this site:
- http://www.hca.wa.gov/medicaid/provider/pages/provideronemanuals.aspx
- Find your manual to review.

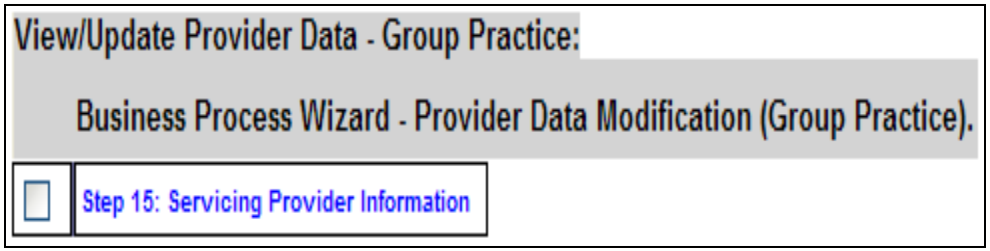
Enroll a New Rendering Provider

Enroll a New Rendering Provider- Existing Provider

- Log into ProviderOne using the File Maintenance or Super User profile.



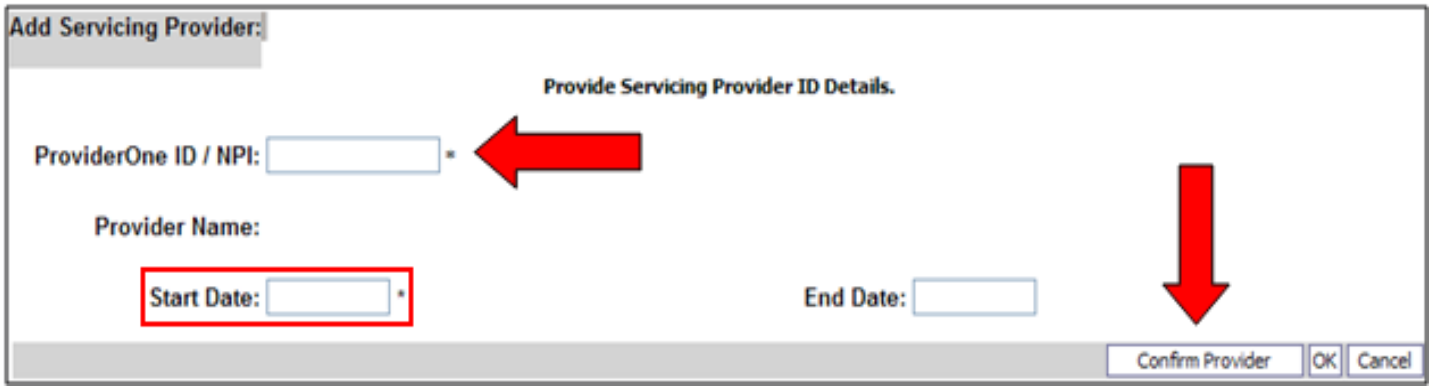
Under Provider click on the hyperlink **"Manage Provider Information"**.



At the Business Process Wizard click on **"Step 15: Servicing Provider Information"**.

Enroll a New Rendering Provider- Existing Provider

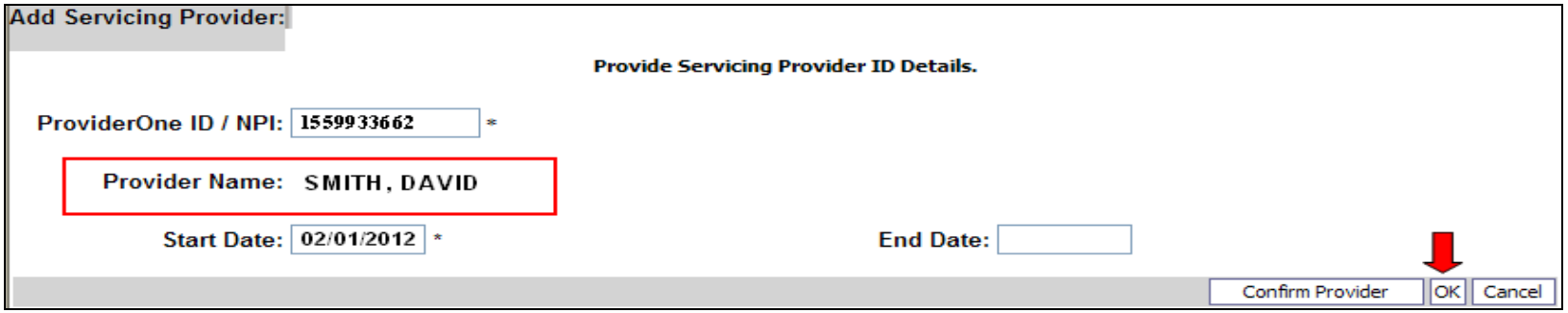
- When the Servicing Provider List opens, click on the **"Add"** button.



- At the Add screen:
  - ✓ Enter the providers NPI.
  - ✓ Enter their start date at your clinic.
  - ✓ Click on the **"Confirm Provider"** button.

Enroll a New Rendering Provider- Existing Provider

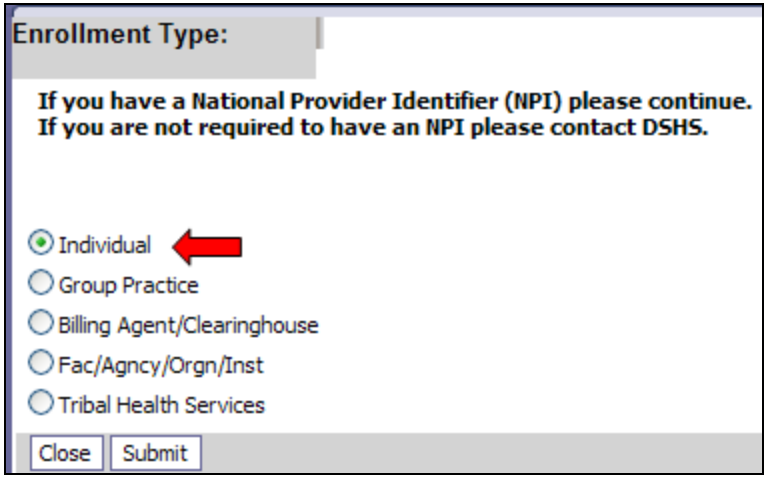
- If the provider is already entered into ProviderOne their name will be confirmed.



- Click the **"OK"** button to add the provider to your list.
- Remember to click **"Step 18: Submit Modification for Review"**.
- The State will then review your request.

Adding a New Rendering Provider

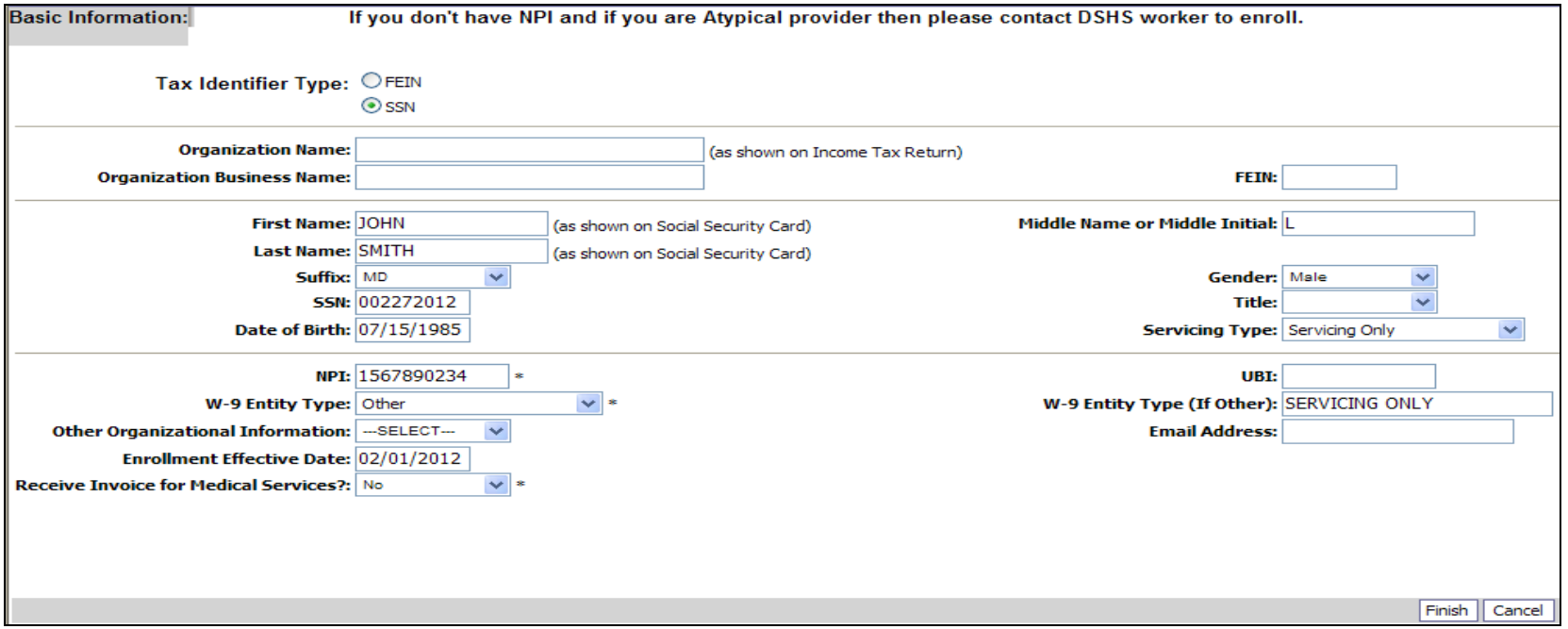
- There are two ways to add a new provider to your domain:
  - ✓ Follow the steps above. When you **"Confirm"** the provider and they are not in the system follow the steps below to enroll them.
  - ✓ At your Portal click on **"Initiate New Enrollment"** hyperlink.



- ✓ Click on **"Individual"** to add the rendering/servicing provider to your domain.
- ✓ Click on the **"Submit"** button.

Adding a New Rendering Provider

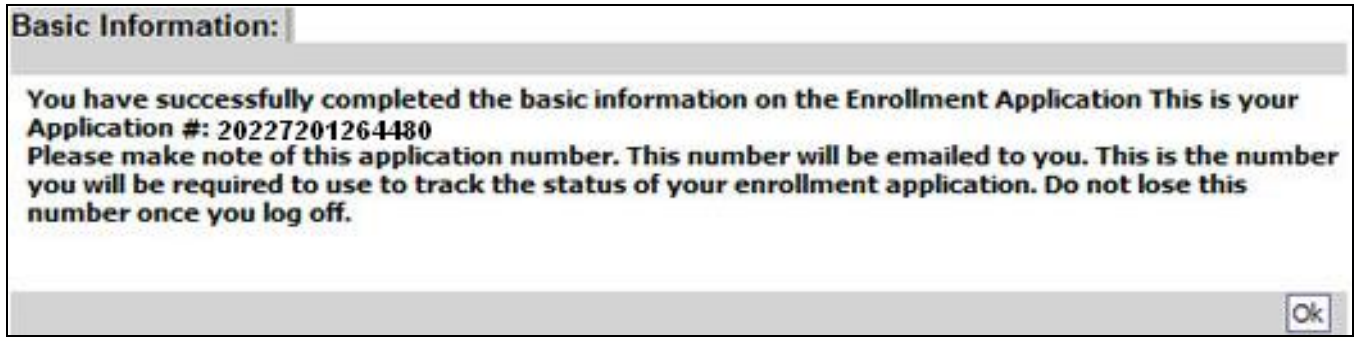
- At the Basic Information page for the rendering provider enrollment:



- ✓ **Most important check the SSN radio button!**
- ✓ When filling in the rest of the data fields be sure to select **"Servicing Only"** as the Servicing Type.

Adding a New Rendering Provider

- Once the Basic Information page is filled in click the **"Finish"** button.
- The basic information on the enrollment application is submitted into ProviderOne which generates the Application number.



- Be sure to record this application number for use in tracking the status of the enrollment application. Then click **"OK"**

Adding a New Rendering Provider

- The Business Process Wizard - Step 1 is complete.

Close | Required Credentials | Undo Update

Important - Step 11: EDI Submission Method is REQUIRED if FTP/Web Batch Submitter or Retrieving 835s.

View/Update Provider Data - Individual:

Business Process Wizard - Provider Data Modification (Individual). In order to finalize submission of your requested - Su

Step	Required	Last Modification Date	Last Review Date	Status
Step 1: Basic Information	Required	03/01/2012	03/01/2012	Complete
Step 2: Locations	Not Required			Incomplete
Step 3: Specializations	Required			Incomplete
Step 4: Ownership Details	Not Required			Incomplete
Step 5: Licenses and Certifications	Required			Incomplete
Step 6: Training and Education	Optional			Incomplete
Step 7: Identifiers	Optional			Incomplete
Step 8: Contract Details	Not Required			Incomplete
Step 9: Federal Tax Details	Optional			Incomplete
Step 10: Invoice Details	Optional			Incomplete
Step 11: EDI Submission Method	Optional			Incomplete
Step 12: EDI Billing Software Details	Optional			Incomplete
Step 13: EDI Submitter Details	Optional			Incomplete
Step 14: EDI Contact Information	Optional			Incomplete
Step 15: Billing Provider Details	Optional			Incomplete
Step 16: Payment Details	Not Required			Incomplete
Step 17: View Union Information	Optional			Incomplete
Step 18: Submit Modification for Review	Required			Incomplete

- ✓ Not all remaining steps are required.

Adding a New Rendering Provider

- The steps with the arrows should be filled out.

Close | Required Credentials | Undo Update

Important - Step 11: EDI Submission Method is REQUIRED if FTP/Web Batch Submitter or Retrieving 835s.

View/Update Provider Data - Individual:

Business Process Wizard - Provider Data Modification (Individual). In order to finalize submission of your requested - Su

	Step	Required	Last Modification Date	Last Review Date	Status
☐	Step 1: Basic Information	Required	03/01/2012	03/01/2012	Complete
☐	Step 2: Locations	Not Required			Incomplete
☐	Step 3: Specializations ⟷	Required			Incomplete
☐	Step 4: Ownership Details	Not Required			Incomplete
☐	Step 5: Licenses and Certifications ⟷	Required			Incomplete
☐	Step 6: Training and Education	Optional			Incomplete
☐	Step 7: Identifiers ⟷	Optional			Incomplete
☐	Step 8: Contract Details	Not Required			Incomplete
☐	Step 9: Federal Tax Details	Optional			Incomplete
☐	Step 10: Invoice Details	Optional			Incomplete
☐	Step 11: EDI Submission Method	Optional			Incomplete
☐	Step 12: EDI Billing Software Details	Optional			Incomplete
☐	Step 13: EDI Submitter Details	Optional			Incomplete
☐	Step 14: EDI Contact Information	Optional			Incomplete
☐	Step 15: Billing Provider Details ⟷	Optional			Incomplete
☐	Step 16: Payment Details	Not Required			Incomplete
☐	Step 17: View Union Information	Optional			Incomplete
☐	Step 18: Submit Modification for Review ⟷	Required			Incomplete

Adding a New Rendering Provider

- Step 3: Specializations
  - ✓ Add Taxonomy here.
- Step 5: Licenses and Certifications
  - ✓ Enter license/certification issued by the Department of Health.
- Step 7: Identifiers
  - ✓ If you have a Drug Enforcement Agency (DEA) number enter it here

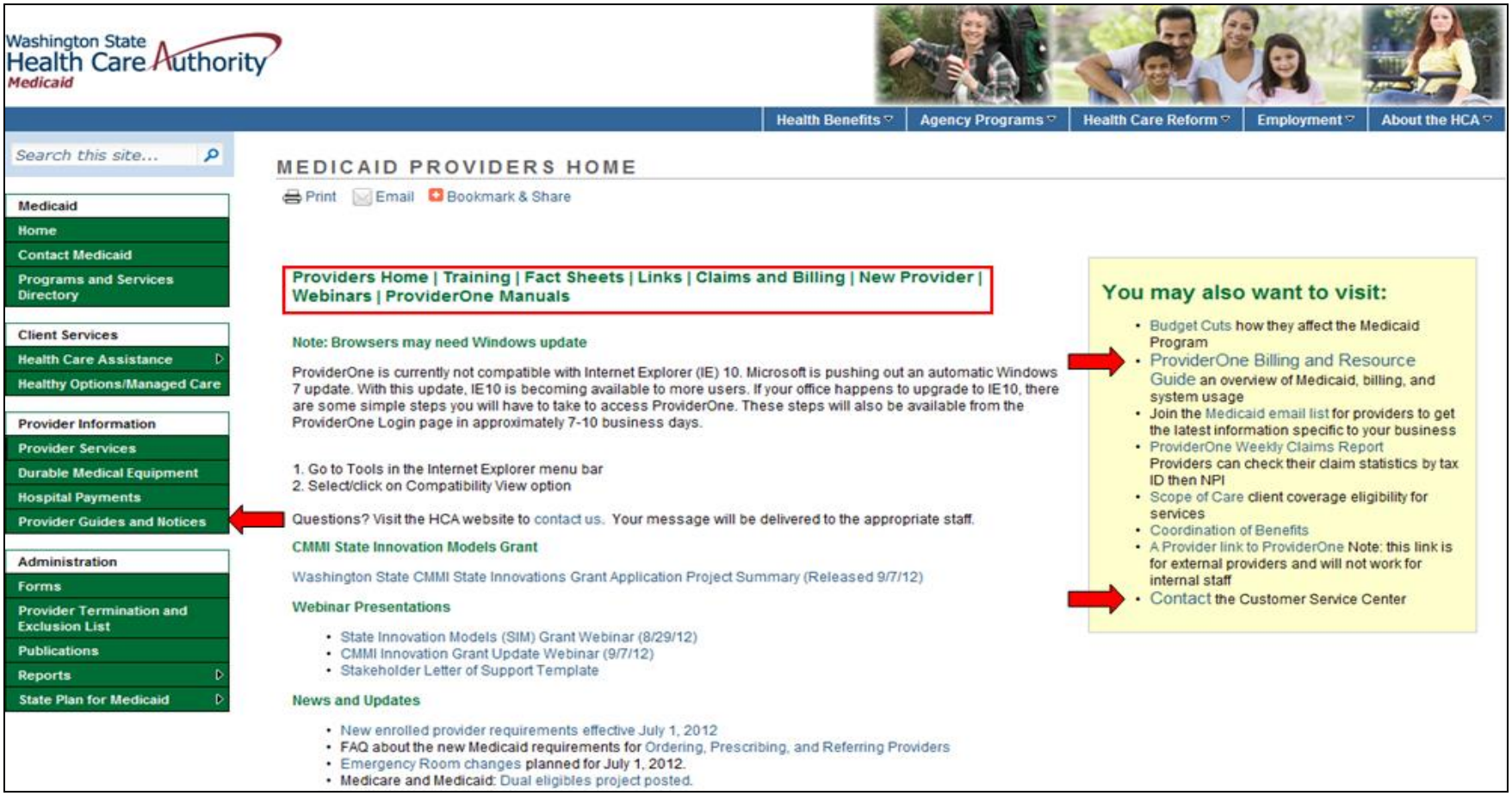
Adding a New Rendering Provider (Cont.)

- Step 15: Billing Provider Details
  - ✓ Add the NPI and Name of clinic that will bill for this rendering provider's services.
- Step 18: Submit Modification for Review
  - ✓ Open this and click the Submit Button to send to the State for approval.
- Send in all required supporting documentation (CPA, Certifications, etc)

Online Services

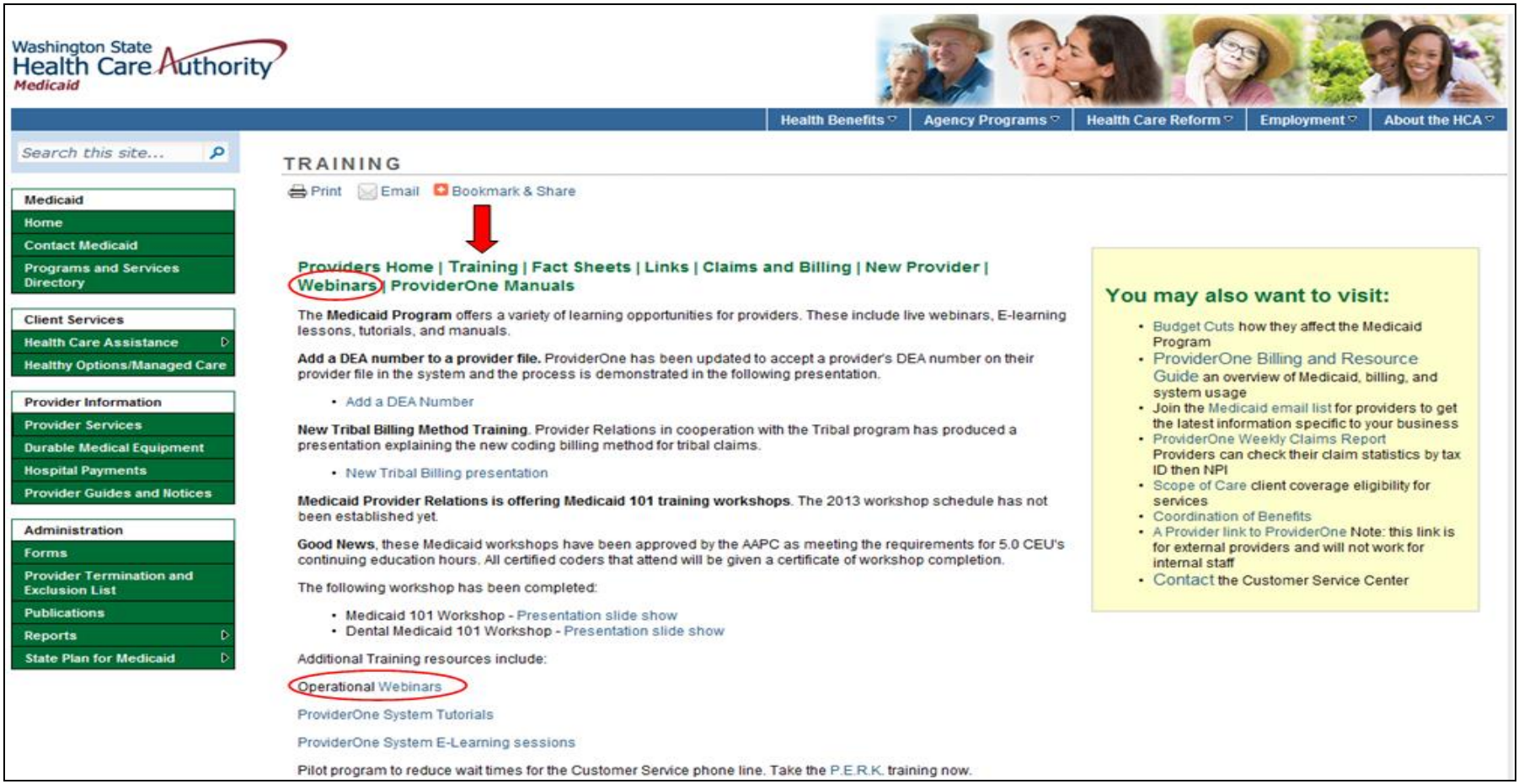
Online Services

- Provider's One-Stop Shopping Website
  - ✓ http://www.hca.wa.gov/medicaid/Provider/Pages/index.aspx



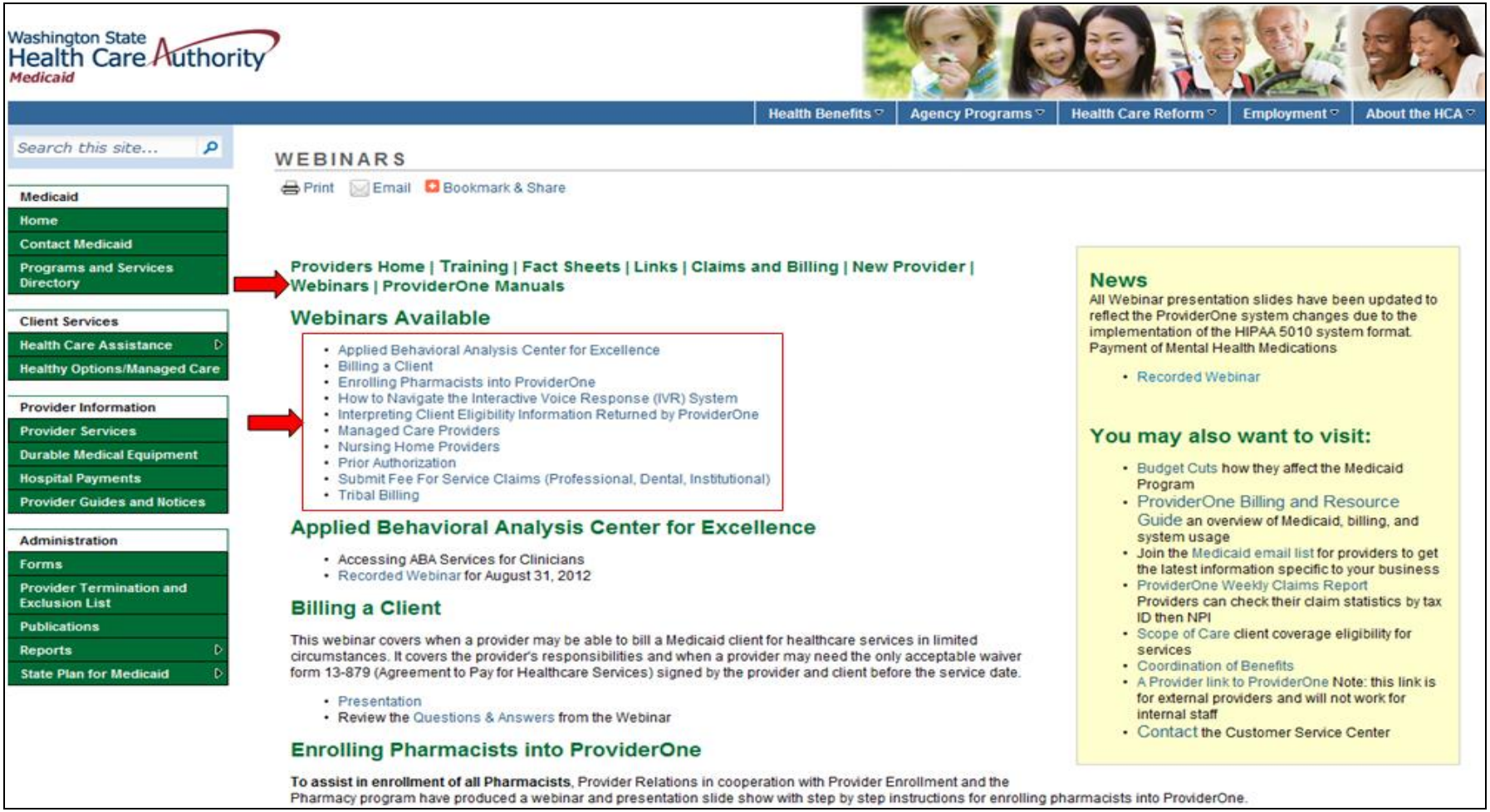
Online Services

- Provider's One-Stop Shopping Website (cont'd)
  - ✓ Training tab



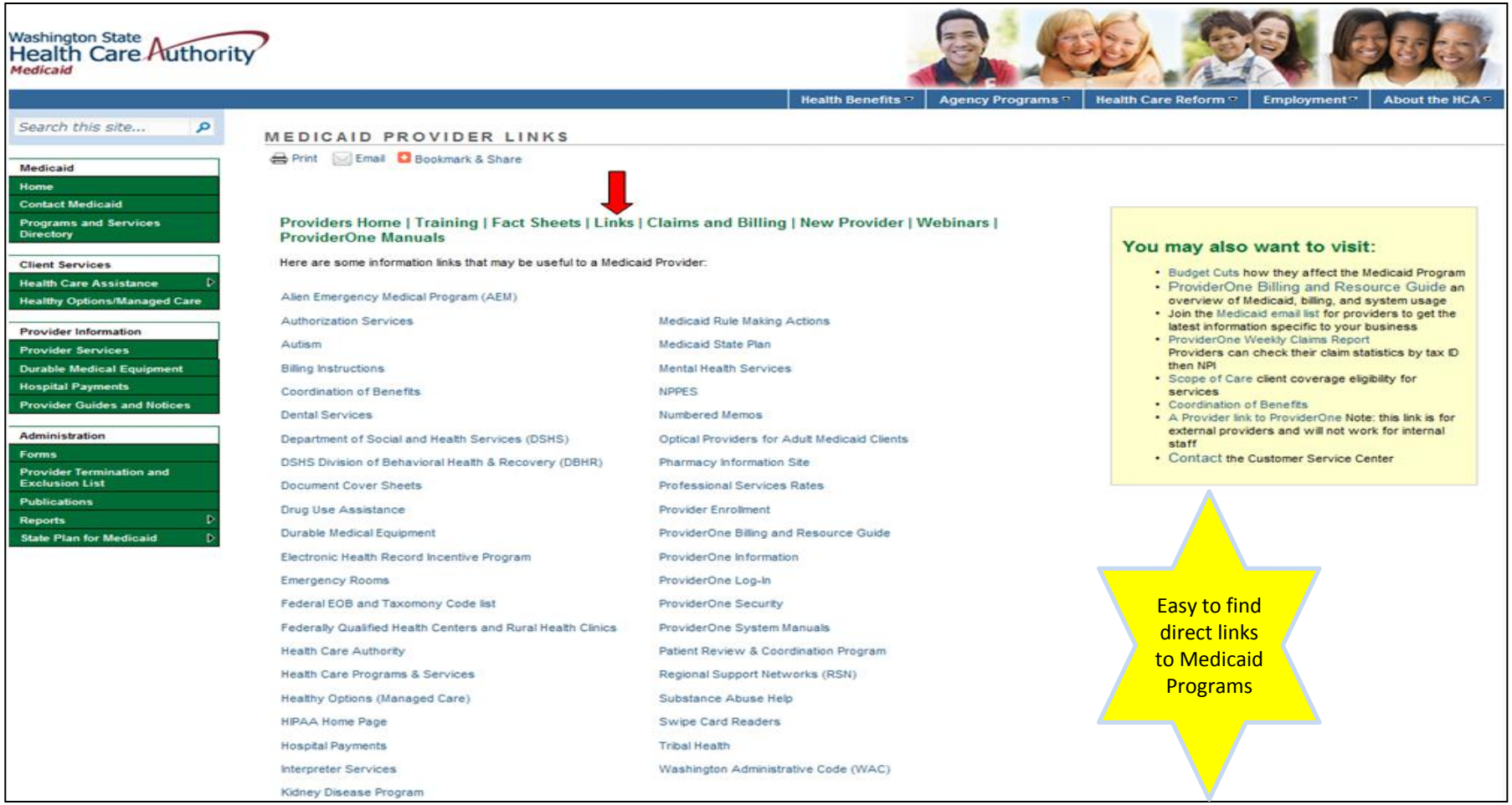
Online Services

- Provider's One-Stop Shopping Website (cont'd)
  - ✓ Webinars with each hyperlink



Online Services

- Provider's One-Stop Shopping Website (cont'd)
  - ✓ Links Tab



Online Services

- ProviderOne Billing and Resource

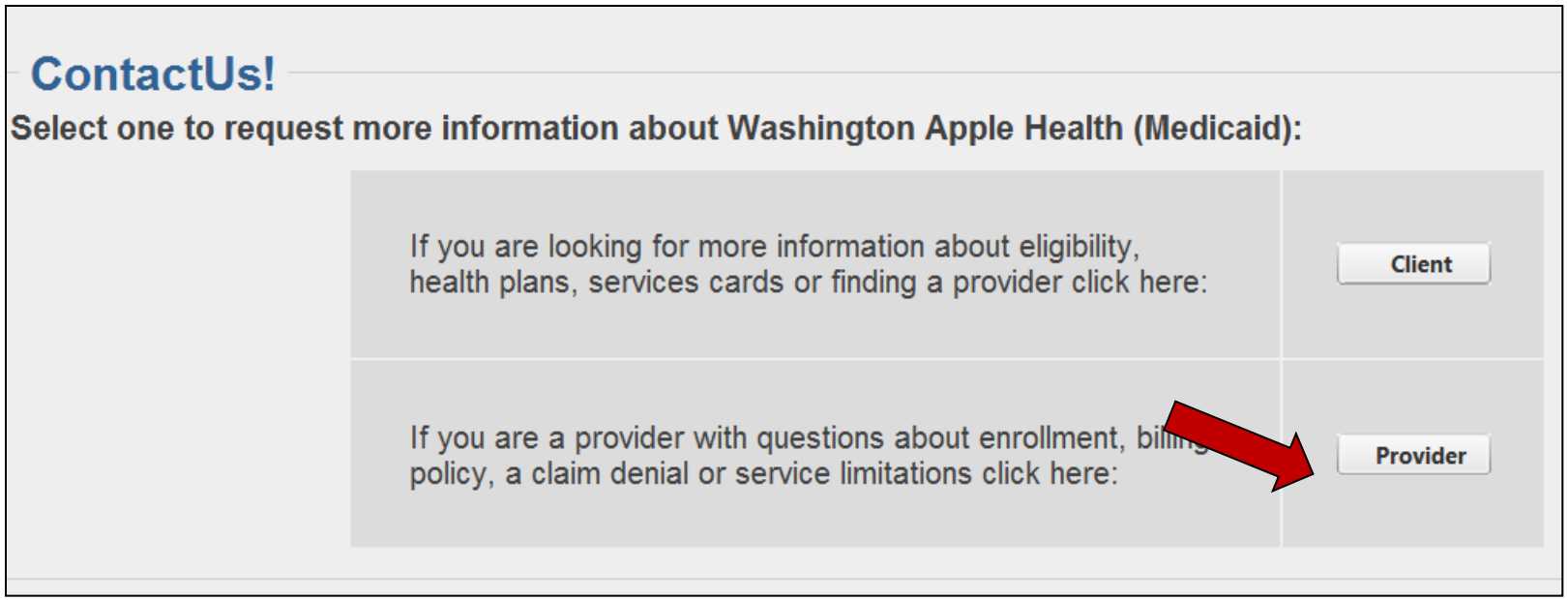
ProviderOne Billing and Resource Guide

http://www.hca.wa.gov/medicaid/billing/pages/providerone_billing_and_resource_guide.aspx

This Guide:

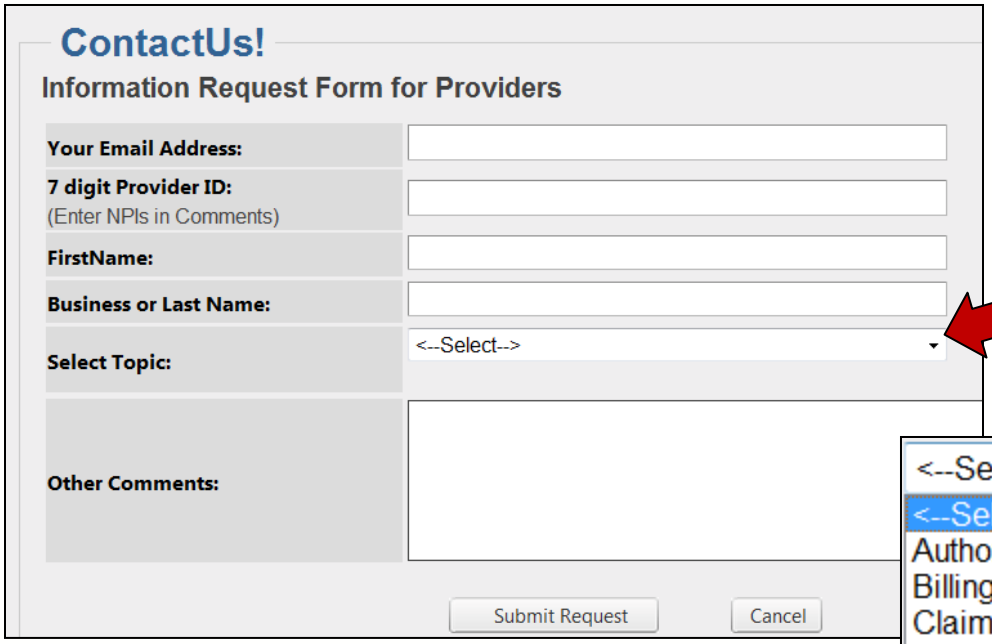
- Provides general information that applies to most Medicaid providers.
- Takes providers through the process for billing the Medicaid Program of the Health Care Authority for covered services delivered to eligible clients.

Contact Us

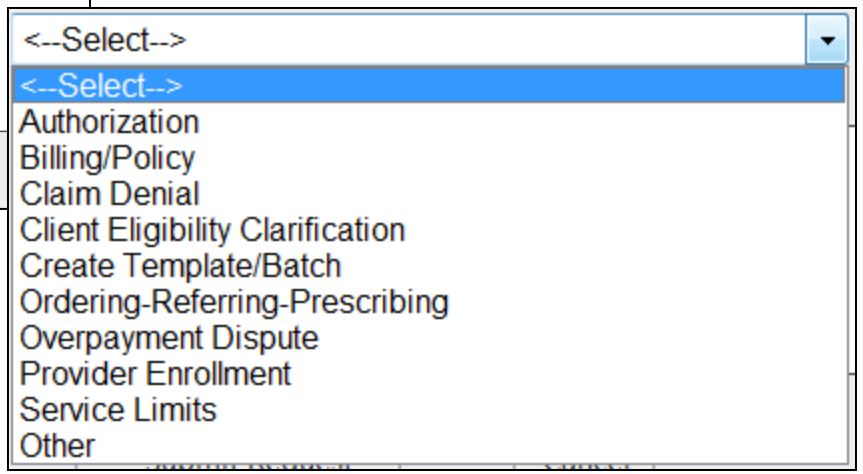


https://fortress.wa.gov/dshs/p1contactus/

Contact Us



- Using the drop down Select Topic, gives the following topics to choose from:



- 48 hour turnaround for **Service Limit** checks
  - ✓ Be sure to include the Date of Service (DOS)
  - ✓ Procedure Code and the date range for search
  - ✓ ProviderOne Domain number

Contact Us

ContactUs!

Information Request Form for Providers

Your Email Address:	providerrelations@hca.wa.gov
7 digit Provider ID: (Enter NPIs in Comments)	1223333
FirstName:	Marci
Business or Last Name:	PRU Dental
Select Topic:	Service Limits

Washington Apple Health

Client ID	002451234WA	**AND: Date of Service (mm/dd/yyyy)**	6/5/2014
Procedure Code:	D1110	**Type of service:**	Prophy
Other Comments:	NPI 1234567890 - Please check D1110 for last 6 months. Thank you!		

Submit Request Cancel

All responses to this box will be via email

Online Resources

➢ Helpful Links Related To Client Eligibility

For the following fact sheets, use the hyperlink listed below:

- Client Services Card Fact Sheet
- Client Eligibility Verification Fact Sheet
- Interactive Voice Response Fact Sheet
- Magnetic Card Reader Fact Sheet
- http://www.hca.wa.gov/medicaid/provider/pages/factsheets.aspx

E-Learning webinar on how to check eligibility in ProviderOne:
http://www.hca.wa.gov/medicaid/provider/Pages/webinar.aspx

- Instructions available in Program Update memo dated May 31, 2012

Self-paced online tutorial on how to check Medicaid eligibility:
http://www.hca.wa.gov/medicaid/ProviderOne/pages/phase1/tutorials.aspx

ProviderOne Billing and Resource Guide:
http://www.hca.wa.gov/medicaid/provider/Pages/providerone_billing_and_resource_guide.aspx

Online Resources

Provider Training website for links to recorded Webinars, E-Learning, and Manuals

- http://www.hca.wa.gov/medicaid/provider/pages/training.aspx

Provider Enrollment website

- http://www.hca.wa.gov/medicaid/provider/pages/newprovider.aspx

Billing Questions

- providerrelations@hca.wa.gov


Q
A